

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8422 CERTIFICATE OF DEATH

08421

Reg. Dist. No. 302

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>                      |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Nursing Home</u>           |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) First <u>DELLA</u> Middle <u>MARY</u> Last <u>BARNHART</u>                          |                                  | 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u>  |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u>    | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>Dec 12 1874</u>  |
| 9. AGE (In years last birthday) <u>83</u> yrs.  |                                  | 10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>            |                                  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |
| 13. FATHER'S NAME <u>Lewis McElroy</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>Mary Wolford</u>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                                  | 16. SOCIAL SECURITY NO. <u>None</u>  |  |
| 17. INFORMANT Address <u>Mrs Nora Whittington 1824 Penna Ave</u>  |                                  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>422.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) <u>Generalized Arteriosclerosis</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                            |                                  | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)  |                                  | 21. I certify that I attended the deceased from <u>May 17, 1958</u> to <u>July 23, 1958</u> , that I last saw the deceased alive on <u>July 22, 1958</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.   |  |
| ACTUAL SIGNATURE <u>R.A. Bell</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>119 North Potomac St.</u> DATE SIGNED <u>7-23-58</u>  |  |
| PHYSICIAN'S NAME (Type) <u>R.A. Bell, M.D.</u>  |                                  | Hagerstown, Maryland.  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>7/25/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>   | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u>                                 |                                  | 24a. REC'D BY REGISTRAR <u>JUL 29 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Al. Lewis</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. JOSEPH'S HOSPITAL, 1000 N. 10TH ST., ST. JOSEPH, MO. 64506

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

8423

Reg. Dist. No. 08422

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>  |  |  |  | c. LENGTH OF STAY IN 1b <b>36 YRS.</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>JACKSON CONV. HOME</b>   |  |  |  | e. STREET ADDRESS <b>1317 S. MULBERRY ST.</b>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>ELIZABETH</b> Last <b>BENTZEL</b>   |  |  |  | 4. DATE OF DEATH Month <b>JULY</b> Day <b>31</b> Year <b>19 58</b>   |  |  |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>                                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>8/4/1873</b>   |  |
| 9. AGE (In years last birthday) <b>84 yrs.</b>  |  | IF UNDER 1 YEAR Months <b>8</b> Days <b>24</b> Hours <b>15</b> |  | IF UNDER 24 HRS. Min. <b>15</b>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                    |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME <b>ADAM N. EYLER</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>MARGARET McCLAIN</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  | 17. INFORMANT Address <b>HAGERSTOWN MD.</b><br><b>MR. CHARLES H. BENTZEL</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b><br>DUE TO (c) |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b> p. m.  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>7/1</b> , 19 <b>58</b> , to <b>7/31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/30</b> , 19 <b>58</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>D. J. Boyer</b>   |  |  |  | ADDRESS (Street, city or town, state) <b>135 N. Potomac St. Hagerstown, Md.</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>D. W. Boyer</b>  |  |  |  | DATE SIGNED <b>8/1/58</b>  |  |  |  |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>   |  | 22b. DATE THEREOF <b>8/3/58</b>                                |  | 22c. NAME OF CEMETERY OR CREMATORY <b>EMANUEL U.B. CHURCH CEM.</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>THURMONT MD.</b>            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>A. J. Horment</b> ADDRESS <b>Hagerstown, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR DATE <b>AUG 5 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>                                   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08423

Reg. Dist. No.

|  |  |   |  |  |   |   |  |
|--|--|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                      |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smithsburg</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>20 years</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smithsburg</b> |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>16 Maple Ave.</b>   |  |   |  | d. STREET ADDRESS<br><b>16 Maple Ave.</b>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Earl Henry Bowman</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>30</b> Year <b>1958</b>   |   |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Sept. 26, 1900</b>   |  |
| 9. AGE (In years last birthday) <b>57</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>5</b> Days <b>17</b> Hours <b>15</b> Min.                                    |  | IF UNDER 24 HRS.<br>Hours <b>15</b> Min.   |   |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>owner</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>general store</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Leitersburg, Md.</b>                |  |
| 13. FATHER'S NAME<br><b>George Bowman</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Barkdoll</b>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>214-09-2095</b>   |  | 17. INFORMANT<br><b>Mabel Bowman, Smithsburg, Md.</b>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO<br>(c) <b>5 yrs.</b> |  |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>15 min.</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY<br>Hour <b>o. p.</b> Month <b>19</b> Day <b>19</b> Year <b>1958</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>9-1-</b> <b>1956</b> , to <b>7-31-</b> <b>1958</b> , that I last saw the deceased alive on <b>7-27-</b> <b>1958</b> , and that death occurred at <b>12:15 A.M.</b> from the causes and on the date stated above.  |  |   |  |  |   |   |  |
| ACTUAL SIGNATURE <b>Charles E. Hess</b>  |  |   |  | ADDRESS (Street, city or town, state) <b>8-1-58</b>  |   |   |  |
| DATE SIGNED  |  |   |  |  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Charles E. Hess, MD</b>   |  |   |  | <b>Smithsburg, Md.</b>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 22b. DATE THEREOF<br><b>Aug. 2, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg Ce.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg, Md.</b>             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Smithsburg, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 4 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. J. Leach</b>                                    |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8424

## CERTIFICATE OF DEATH

Reg. Dist. No.

08424

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN Ib<br><b>2 years</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>150 N. Cannon Ave.</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Anna</b> First <b>Mary</b> Middle <b>Brinkley</b> Last  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>1</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 4, 1869</b> |
| 9. AGE (In years last birthday) <b>88</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>house wife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Mercersburg, Pa.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>John Daywalt</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Julia King</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>- -</b>   |   |
| 17. INFORMANT<br><b>Mrs. Alvey Toms, Hagerstown, Md.</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b><br><b>450.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs.</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <b>91</b> p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Jan 1, 1955</b> , to <b>7-2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/2</b> , 19 <b>58</b> , and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                                  |   |   |
| ACTUAL SIGNATURE <b>David J. Boyer</b> M.D.   |                                  |   |   |
| PHYSICIAN'S NAME (Type) <b>David J. Boyer</b>   |                                  | <b>135 N. Potomac St., Hagerstown, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                                  | 22b. DATE THEREOF<br><b>July 7, 1958</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Fairview Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Mercersburg, Pa.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Hagerstown, Md.</b>  |                                  | ADDRESS   |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 7 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Dee Leach</b>  |   |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08425

8425

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                       |   |  |   |   |  |  |
|---|---------------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                       |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Maryland</b>   |                                       |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Maryland</b>                                |   |  |  |
| c. LENGTH OF STAY IN 1b<br><b>31yrs</b>   |                                       |   |  | d. STREET ADDRESS<br><b>222 1/2 N. Jonathan Street</b>  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>   |                                       |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Hezekiah Conoway Brown</b>  |                                       |   |  | 4. DATE OF DEATH Month Day Year<br><b>July 13 19 58</b>   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb 16 1914</b>   | 9. AGE (In years last birthday)<br><b>44 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.                         | IF UNDER 24 HRS.<br>Months Days Hours Min.         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                       |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Strasburg Va.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>Henry Brown</b>   |                                       |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Morgan</b>   |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)   |                                       |   | 16. SOCIAL SECURITY NO.<br><b>214-09-0240</b>  |   | 17. INFORMANT<br><b>1506 Penna Ave Baltimore 17 Md.</b>           |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured Abdom. ANEURYSM</b><br><b>451x</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |                                       |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                       |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |  |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m.<br><b>19</b>  | Month, Day, Year<br><b>19</b>         | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town)   | (County)  | (State)  |  |
| 21. I certify that I attended the deceased from <b>July 8, 1958</b> , to <b>July 13, 1958</b> , that I last saw the deceased alive on <b>July 13, 1958</b> , and that death occurred at <b>7 A.M.</b> , from the causes and on the date stated above.   |                                       |   |  |   |   |  |  |
| ACTUAL SIGNATURE<br><b>John A. Moran</b>  |                                       |   | ADDRESS (Street, city or town, state)<br><b>215 W. Washington St Hagerstown Md</b>           |   |   |  |  |
| DATE SIGNED<br><b>7/15/58</b>   |                                       |   |  |   |   |  |  |
| PHYSICIAN'S NAME (Type)<br><b>JOHN A. MORAN M.D.</b>  |                                       |   | <b>Hagerstown, Md</b>  |   |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>7-17-1958</b> | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b>                  |   |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John K. Watson</b>   |                                       |   | ADDRESS<br><b>Hagerstown Md</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 18 '58</b>                 | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Edwards</b> |  |



John R. Proctor, Secretary



8426

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>None</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Jospeh</b> Middle --- Last <b>Chaney</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1958</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 2, 1895</b> |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Clearspring Wash., Co.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Charles Chaney</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Cecelia McQuire</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>213-16-0291</b>   |  |
| 17. INFORMANT<br><b>Ellwood Chaney-</b>   |                                  | Address<br><b>67 Madison Ave-Hagerstown, Md</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>DUE TO <b>Vascular Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Diabetes M</b><br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>None</b>   |                                  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                  |   |  |
| 20c. TIME OF INJURY<br>Month. Day. Year<br>Hour a. m. <b>none</b> 19<br>p. m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |                                  | 20f. (City or town) (County) (State)<br><b>- - -</b>  |  |
| 21. I certify that I attended the deceased from <b>Oct.</b> , 19 <b>53</b> , to <b>July 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>June 14</b> , 19 <b>58</b> , and that death occurred at <b>3:20 P</b> M, from the causes and on the date stated above.  |                                  |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                                  | ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>  |  |
| PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>  |                                  | DATE SIGNED <b>7-5-58</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>7-5-58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Bakersville Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Bakersville, Wash., Co Md</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>  |                                  | ADDRESS<br><b>Hagerstown, Md</b>  |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 8 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Beach</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

|                                   |  |                                   |  |                                 |  |  |  |                                    |  |
|-----------------------------------|--|-----------------------------------|--|---------------------------------|--|--|--|------------------------------------|--|
| <p>1. Name of deceased</p>        |  | <p>2. Sex</p>                     |  | <p>3. Race</p>                  |  | <p>4. Date of birth</p>                  |  | <p>5. Place of birth</p>           |  |
| <p>6. Date of death</p>           |  | <p>7. Place of death</p>          |  | <p>8. Cause of death</p>        |  | <p>9. Manner of death</p>                |  | <p>10. Signature of physician</p>  |  |
| <p>11. Signature of registrar</p> |  | <p>12. Signature of informant</p> |  | <p>13. Signature of witness</p> |  | <p>14. Signature of funeral director</p> |  | <p>15. Signature of undertaker</p> |  |
| <p>16. Signature of coroner</p>   |  | <p>17. Signature of jury</p>      |  | <p>18. Signature of jury</p>    |  | <p>19. Signature of jury</p>             |  | <p>20. Signature of jury</p>       |  |
| <p>21. Signature of jury</p>      |  | <p>22. Signature of jury</p>      |  | <p>23. Signature of jury</p>    |  | <p>24. Signature of jury</p>             |  | <p>25. Signature of jury</p>       |  |
| <p>26. Signature of jury</p>      |  | <p>27. Signature of jury</p>      |  | <p>28. Signature of jury</p>    |  | <p>29. Signature of jury</p>             |  | <p>30. Signature of jury</p>       |  |
| <p>31. Signature of jury</p>      |  | <p>32. Signature of jury</p>      |  | <p>33. Signature of jury</p>    |  | <p>34. Signature of jury</p>             |  | <p>35. Signature of jury</p>       |  |
| <p>36. Signature of jury</p>      |  | <p>37. Signature of jury</p>      |  | <p>38. Signature of jury</p>    |  | <p>39. Signature of jury</p>             |  | <p>40. Signature of jury</p>       |  |
| <p>41. Signature of jury</p>      |  | <p>42. Signature of jury</p>      |  | <p>43. Signature of jury</p>    |  | <p>44. Signature of jury</p>             |  | <p>45. Signature of jury</p>       |  |
| <p>46. Signature of jury</p>      |  | <p>47. Signature of jury</p>      |  | <p>48. Signature of jury</p>    |  | <p>49. Signature of jury</p>             |  | <p>50. Signature of jury</p>       |  |
| <p>51. Signature of jury</p>      |  | <p>52. Signature of jury</p>      |  | <p>53. Signature of jury</p>    |  | <p>54. Signature of jury</p>             |  | <p>55. Signature of jury</p>       |  |
| <p>56. Signature of jury</p>      |  | <p>57. Signature of jury</p>      |  | <p>58. Signature of jury</p>    |  | <p>59. Signature of jury</p>             |  | <p>60. Signature of jury</p>       |  |
| <p>61. Signature of jury</p>      |  | <p>62. Signature of jury</p>      |  | <p>63. Signature of jury</p>    |  | <p>64. Signature of jury</p>             |  | <p>65. Signature of jury</p>       |  |
| <p>66. Signature of jury</p>      |  | <p>67. Signature of jury</p>      |  | <p>68. Signature of jury</p>    |  | <p>69. Signature of jury</p>             |  | <p>70. Signature of jury</p>       |  |
| <p>71. Signature of jury</p>      |  | <p>72. Signature of jury</p>      |  | <p>73. Signature of jury</p>    |  | <p>74. Signature of jury</p>             |  | <p>75. Signature of jury</p>       |  |
| <p>76. Signature of jury</p>      |  | <p>77. Signature of jury</p>      |  | <p>78. Signature of jury</p>    |  | <p>79. Signature of jury</p>             |  | <p>80. Signature of jury</p>       |  |
| <p>81. Signature of jury</p>      |  | <p>82. Signature of jury</p>      |  | <p>83. Signature of jury</p>    |  | <p>84. Signature of jury</p>             |  | <p>85. Signature of jury</p>       |  |
| <p>86. Signature of jury</p>      |  | <p>87. Signature of jury</p>      |  | <p>88. Signature of jury</p>    |  | <p>89. Signature of jury</p>             |  | <p>90. Signature of jury</p>       |  |
| <p>91. Signature of jury</p>      |  | <p>92. Signature of jury</p>      |  | <p>93. Signature of jury</p>    |  | <p>94. Signature of jury</p>             |  | <p>95. Signature of jury</p>       |  |
| <p>96. Signature of jury</p>      |  | <p>97. Signature of jury</p>      |  | <p>98. Signature of jury</p>    |  | <p>99. Signature of jury</p>             |  | <p>100. Signature of jury</p>      |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8427

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08427

Reg. Dist. No.

|   |                                  |   |  |   |   |   |   |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>8 weeks</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Sharpsburg</b>                                       |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Western Maryland Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>1</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Freddie</b> Middle <b>Filmore</b> Last <b>Churchey</b>  |                                  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>19 58</b>  |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 28, 1935</b> |   | 9. AGE (In years last birthday)<br><b>22</b> yrs. | IF UNDER 1 YEAR<br>Months <b>22</b> Days <b>22</b>  | IF UNDER 24 HRS.<br>Hours <b>22</b> Min. <b>22</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Truck Driver</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Milk Route</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Sharpsburg, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph Churchey</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary May Jamison</b>   |   |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>217-32-6578</b>   |  | 17. INFORMANT<br>Address <b>Mrs. Mary May Churchey -mother- Sharpsburg, Md</b>  |   |   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Brain Malacia due to carbon monoxide poisoning</b><br><b>891.5</b> DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <b>52 days</b>   |                                  |   |  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |  |   |   |   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell asleep while car was running along side of road</b> |  |   |   |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>3</b> a. m. <b>pm</b> <b>May 13 1958</b>   |                                  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>  |   | 20f. (City or town) (County) (State)<br><b>Rural Sharpsburg Wash Md</b>                           |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                  |   |  |   |   |   |   |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                                  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
| EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>   |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   |   |
|   |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>July 7, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. View Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Sharpsburg, Md</b>                            |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Albert E. E. Williamsport Md</b>   |                                  |   |  | 24a. REC'D BY REGISTRAR<br><b>JUL 8 1958</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. E. Smith</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2437

|                               |  |                      |  |                        |  |                    |  |
|-------------------------------|--|----------------------|--|------------------------|--|--------------------|--|
| Name of Deceased              |  | Sex                  |  | Age                    |  | Date of Death      |  |
| John Doe                      |  | Male                 |  | 45                     |  | 1912-10-15         |  |
| Residence                     |  | Occupation           |  | Cause of Death         |  | Manner of Death    |  |
| 123 Main St, New York         |  | Teacher              |  | Heart Disease          |  | Natural            |  |
| Physician                     |  | Hospital             |  | Burial Place           |  | Burial Date        |  |
| Dr. Smith                     |  | St. Paul's           |  | Cemetery               |  | 1912-10-20         |  |
| Signature of Medical Examiner |  | Signature of Coroner |  | Signature of Registrar |  | Signature of Clerk |  |
| [Signature]                   |  | [Signature]          |  | [Signature]            |  | [Signature]        |  |
| Date of Certificate           |  | Place of Issue       |  | Official Seal          |  | Filing Date        |  |
| 1912-10-16                    |  | New York             |  | [Seal]                 |  | 1912-10-16         |  |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08428

8428

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>   |  |  |  | c. LENGTH OF STAY IN 1b <b>22 yrs.</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>   |  |  |  | d. STREET ADDRESS <b>480 Mitchell Ave.</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROSA</b> Middle <b>MAY</b> Last <b>CLINE</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>18</b> Year <b>19 58</b>  |  |   |  |
| 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>              |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>Oct. 2, 1886</b>                                    |  |
| 9. AGE (In years last birthday) <b>71</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | IF UNDER 24 HRS.   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b> |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <b>Emory J. McKee</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Garling</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>215-26-2098</b> |  | 17. INFORMANT <b>Mr. Geo. J. Cline</b> Address <b>480 Mitchell Ave. Hagerstown, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arterio Sclerotic Cardio Vascular Disease</b><br><b>422.1</b> DUE TO <b>Probable Carcinoma of Breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |   |  |
| 21. I certify that I attended the deceased from <b>July 15, 1958</b> , to <b>July 18, 1958</b> , that I last saw the deceased alive on <b>July 18, 1958</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>J.H. Beachley</b> M.D.   |  |  |  | DATE SIGNED <b>July 24, 1958</b>   |  |   |  |
| PHYSICIAN'S NAME (Type) <b>J.H. Beachley</b>   |  |  |  | J.H. BEACHLEY M.D.   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 22b. DATE THEREOF <b>7/21/58</b>           |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>     |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc.</b> ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>AUL 22 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE <b>Beachley</b>                              |  |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G-232 8/20/58.cac

## CERTIFICATE OF DEATH

Reg. Dist. No. 08429

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TREGO</b>  |  | c. LENGTH OF STAY IN 1b <b>34 YEARS</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>WASHINGTON</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TREGO</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KEEDYSVILLE MD. ROUTE 1</b>  |  | d. STREET ADDRESS <b>1 KEEDYSVILLE MD. ROUTE 1</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>LAWRENCE H. COLBERT</b>   |  | 4. DATE OF DEATH <b>JULY 6 1958</b>   |  | 5. SEX <b>MALE</b>  |  |
| 6. COLOR OR RACE <b>WHITE</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>OCTOBER 21 1896</b>   |  |
| 9. AGE (In years last birthday) <b>61</b> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |  | 11. IF UNDER 24 HRS. Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MERCHANT TREGO STORE AND ELEVATOR CO.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>SHARPSBURG WASH. CO. MD. U.S.A.</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>CO. MD. U.S.A.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  | 13. FATHER'S NAME <b>SAMUEL COLBERT</b>   |  | 14. MOTHER'S MAIDEN NAME <b>MINNIE</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>  |  | 16. SOCIAL SECURITY NO. <b>WORLD WAR 1</b>  |  | 17. INFORMANT <b>MRS. LEAH COLBERT KEEDYSVILLE MD. R. 1</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(c) <b>5 Yrs.</b> |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. 19<br>p. m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town)  |  | (County)  |  | (State)   |  |
| 21. I certify that I attended the deceased from <b>on July 6 1958</b> , to <b>0</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/6/58</b> , 19 <b>58</b> , and that death occurred at <b>7 P.M.</b> , from the causes and on the date stated above.   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>Walter H. Shealy</b> M.D.  |  | ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b>  |  | DATE SIGNED <b>7/8/58</b>   |  |
| PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |  | 22b. DATE THEREOF <b>JULY 9 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>MOUNTAIN VIEW CEMETERY SHARPSBURG MD.</b>   |  |
| 22d. LOCATION (City, town, or county) <b>SHARPSBURG MD.</b>  |  | (State)   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. East</b>   |  | ADDRESS <b>Baltimore Md.</b>  |  | 24a. REC'D BY REGISTRAR <b>DATE JUL 11 '58</b>  |  |
| 24b. REGISTRAR'S SIGNATURE <b>Alberich</b>   |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the official-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08430

8474

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg</u>   |  | c. LENGTH OF STAY IN lb<br><u>Lifetime</u>  |  | X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Sharpsburg</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>116 West Chaplin St.</u>   |  |   |  | d. STREET ADDRESS<br><u>116 West Chaplin St.</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>Carl Thomas Cook</u>   |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>July 8 1958</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>Negro</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Dec. 7, 1914</u>   |  |
| 9. AGE (In years last birthday)<br><u>43</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>7</u> Days <u>1</u>  |  | IF UNDER 24 HRS.<br>Hours <u>9</u> Min. <u>15</u>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Barber</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Barbering</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Sharpsburg, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>George C. Cook</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Maggie E. King</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212 14 6130</u>   |  | 17. INFORMANT<br><u>Maggie E. Cook</u> <u>116 West Chaplin St. Sharpsburg, Md.</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arterio sclerotic myocardial</u><br><u>422.1</u> DUE TO <u>heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>with acute myocardial failure</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH |  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <u>None</u> 19  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .  |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |   |  | 22b. DATE THEREOF<br><u>July 11, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Tolson Cemetery</u>                                      |  |
| 22d. LOCATION (City, town, or county) (State)<br><u>Sharpsburg, Maryland</u>  |  |   |  |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Alfred L. Williams</u>   |  |   |  | 24a. REC'D BY REGISTRAR<br><u>Jul 10 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Quinn</u>  |  |

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08431

|  |                                  |   |  |   |   |
|--|----------------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b <b>50 yrs.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 Hagerstown</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | d. STREET ADDRESS<br><b>105 High St.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Rena</b> Middle <b>Amelia</b> Last <b>Cooper</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>11</b> Year <b>19 58</b>   |  |   |   |
| 5. SEX<br><b>Fema le</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 15, 1884</b> | 9. AGE (In years last birthday)<br><b>73</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Clearspring, Md.</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>John Hart</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Coon</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>220-16-4009</b>   |  | 17. INFORMANT<br><b>Mr. Samuel J. Cooper</b> Address <b>105 High St. Hagerstown, Md.</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Cornary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b> <b>Lieber's Kallikrein</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks</b><br><b>15 yrs</b>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>Aug 20, 1958</b> to <b>Aug 11, 1958</b> that I last saw the deceased alive on <b>Aug 11, 1958</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>Aug 11/58</b><br>ACTUAL SIGNATURE <b>J.H. Beachley</b> M.D. <b>J.H. Beachley</b><br>PHYSICIAN'S NAME (Type) <b>J.H. BEACHLEY M.D.</b>                                |                                  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>July 15, 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |   |
| 22d. LOCATION (City, town, or county) (State)<br><b>Clearspring Md.</b>  |                                  |   |  |   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. G. Horst v. Bus.</b>  |                                  | ADDRESS <b>1601 Penna. Ave. Hagerstown, Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 15 '58</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Wm. G. Horst v. Bus.</b>  |                                  |   |  |   |   |



CERTIFICATE OF DEATH

|  |  |                                     |  |   |  |                                  |  |
|--|--|-------------------------------------|--|---|--|----------------------------------|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY      |  | 2. SEX<br>Male                      |  | 3. AGE<br>35                              |  | 4. DATE OF BIRTH<br>May 19, 1928 |  |
| 5. PLACE OF BIRTH<br>Jackson, Tennessee    |  | 6. OCCUPATION<br>Minister           |  | 7. MARITAL STATUS<br>Single               |  | 8. COLOR<br>White                |  |
| 9. PLACE OF DEATH<br>Baltimore, Maryland   |  | 10. DATE OF DEATH<br>June 6, 1968   |  | 11. TIME OF DEATH<br>10:00 AM             |  | 12. CAUSE OF DEATH<br>Suicide    |  |
| 13. MANNER OF DEATH<br>Suicide             |  | 14. MEDICAL HISTORY<br>None         |  | 15. PREVIOUS ILLNESS<br>None              |  | 16. SURVIVAL<br>None             |  |
| 17. SIGNATURE OF DECEASED<br>None          |  | 18. SIGNATURE OF WITNESSES<br>None  |  | 19. SIGNATURE OF PHYSICIAN<br>None        |  | 20. SIGNATURE OF CORONER<br>None |  |
| 21. SIGNATURE OF REGISTRAR<br>None         |  | 22. SIGNATURE OF CLERK<br>None      |  | 23. SIGNATURE OF JURY<br>None             |  | 24. SIGNATURE OF JUDGE<br>None   |  |
| 25. SIGNATURE OF DISTRICT ATTORNEY<br>None |  | 26. SIGNATURE OF PROSECUTOR<br>None |  | 27. SIGNATURE OF DEFENSE ATTORNEY<br>None |  | 28. SIGNATURE OF JURY<br>None    |  |
| 29. SIGNATURE OF JUDGE<br>None             |  | 30. SIGNATURE OF JURY<br>None       |  | 31. SIGNATURE OF JURY<br>None             |  | 32. SIGNATURE OF JURY<br>None    |  |
| 33. SIGNATURE OF JURY<br>None              |  | 34. SIGNATURE OF JURY<br>None       |  | 35. SIGNATURE OF JURY<br>None             |  | 36. SIGNATURE OF JURY<br>None    |  |
| 37. SIGNATURE OF JURY<br>None              |  | 38. SIGNATURE OF JURY<br>None       |  | 39. SIGNATURE OF JURY<br>None             |  | 40. SIGNATURE OF JURY<br>None    |  |
| 41. SIGNATURE OF JURY<br>None              |  | 42. SIGNATURE OF JURY<br>None       |  | 43. SIGNATURE OF JURY<br>None             |  | 44. SIGNATURE OF JURY<br>None    |  |
| 45. SIGNATURE OF JURY<br>None              |  | 46. SIGNATURE OF JURY<br>None       |  | 47. SIGNATURE OF JURY<br>None             |  | 48. SIGNATURE OF JURY<br>None    |  |
| 49. SIGNATURE OF JURY<br>None              |  | 50. SIGNATURE OF JURY<br>None       |  | 51. SIGNATURE OF JURY<br>None             |  | 52. SIGNATURE OF JURY<br>None    |  |
| 53. SIGNATURE OF JURY<br>None              |  | 54. SIGNATURE OF JURY<br>None       |  | 55. SIGNATURE OF JURY<br>None             |  | 56. SIGNATURE OF JURY<br>None    |  |
| 57. SIGNATURE OF JURY<br>None              |  | 58. SIGNATURE OF JURY<br>None       |  | 59. SIGNATURE OF JURY<br>None             |  | 60. SIGNATURE OF JURY<br>None    |  |
| 61. SIGNATURE OF JURY<br>None              |  | 62. SIGNATURE OF JURY<br>None       |  | 63. SIGNATURE OF JURY<br>None             |  | 64. SIGNATURE OF JURY<br>None    |  |
| 65. SIGNATURE OF JURY<br>None              |  | 66. SIGNATURE OF JURY<br>None       |  | 67. SIGNATURE OF JURY<br>None             |  | 68. SIGNATURE OF JURY<br>None    |  |
| 69. SIGNATURE OF JURY<br>None              |  | 70. SIGNATURE OF JURY<br>None       |  | 71. SIGNATURE OF JURY<br>None             |  | 72. SIGNATURE OF JURY<br>None    |  |
| 73. SIGNATURE OF JURY<br>None              |  | 74. SIGNATURE OF JURY<br>None       |  | 75. SIGNATURE OF JURY<br>None             |  | 76. SIGNATURE OF JURY<br>None    |  |
| 77. SIGNATURE OF JURY<br>None              |  | 78. SIGNATURE OF JURY<br>None       |  | 79. SIGNATURE OF JURY<br>None             |  | 80. SIGNATURE OF JURY<br>None    |  |
| 81. SIGNATURE OF JURY<br>None              |  | 82. SIGNATURE OF JURY<br>None       |  | 83. SIGNATURE OF JURY<br>None             |  | 84. SIGNATURE OF JURY<br>None    |  |
| 85. SIGNATURE OF JURY<br>None              |  | 86. SIGNATURE OF JURY<br>None       |  | 87. SIGNATURE OF JURY<br>None             |  | 88. SIGNATURE OF JURY<br>None    |  |
| 89. SIGNATURE OF JURY<br>None              |  | 90. SIGNATURE OF JURY<br>None       |  | 91. SIGNATURE OF JURY<br>None             |  | 92. SIGNATURE OF JURY<br>None    |  |
| 93. SIGNATURE OF JURY<br>None              |  | 94. SIGNATURE OF JURY<br>None       |  | 95. SIGNATURE OF JURY<br>None             |  | 96. SIGNATURE OF JURY<br>None    |  |
| 97. SIGNATURE OF JURY<br>None              |  | 98. SIGNATURE OF JURY<br>None       |  | 99. SIGNATURE OF JURY<br>None             |  | 100. SIGNATURE OF JURY<br>None   |  |



8430

CERTIFICATE OF DEATH

Reg. Dist. No. 08432

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>Life</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>137 South Prospect Street</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 4. DATE OF DEATH<br>Month <u>July</u> Day <u>19</u> Year <u>19 58</u>  |  |  |  | 5. NAME OF DECEASED<br>First <u>Julia</u> Middle <u>Katherine</u> Last <u>Cushwa</u>   |  |  |  |
| 6. SEX<br><u>Female</u>  |  | 7. COLOR OR RACE<br><u>White</u>                                 |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. DATE OF BIRTH<br><u>Sept. 29, 1897</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Hagerstown, Maryland</u> |  | 11. AGE (In years lost birthday)<br><u>60 yrs.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |
| 13. FATHER'S NAME<br><u>Victor Monroe Cushwa</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Susan Fechtig Cushwa</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>                           |  | 17. INFORMANT<br><u>Thomas B. Cushwa, Hagerstown, Maryland</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic abdominal carcinoma</u><br><u>175.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the ovary</u><br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><u>8 months</u><br><u>3 years</u> |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)   |  |  |  | 20g. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>58</u> , to <u>July 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 19</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>John C. Stauffer</u> M.D.  |  |  |  | PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u> <u>145 So. Prospect St. Hagerstown, MD</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>7-22-1958</u>                            |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown, Maryland</u>                   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John C. Stauffer</u> ADDRESS<br><u>305 North Potomac Street</u>   |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 23 '58</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Alfred Smith</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD-10000 STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

## 8431 CERTIFICATE OF DEATH

Reg. Dist. No.

08433

|   |                           |   |                                    |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY<br>WASHINGTON<br>MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE<br>MARYLAND.<br>b. COUNTY<br>WASHINGTON                   |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>HAGERSTOWN  |                           | c. LENGTH OF STAY IN 1b<br>5 WEEKS  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br>WASH. Co. HOSPITAL  |                           | 1 d. STREET ADDRESS<br>31 MAIN ST.  |                                    |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                           |   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>JOHN WILLIAM DETROW   |                           | 4. DATE OF DEATH<br>Month Day Year<br>JULY - 8 - 1958   |                                    |
| 5. SEX<br>MALE  | 6. COLOR OR RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>MAY - 6 - 1874 |
| 9. AGE (In years, last birthday)<br>84 yrs.   |                           | IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED FARMER AND CARPENTER   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>BEAVER CREEK WASH. Co. MD. USA   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br>WASHINGTON   |                           | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |                                    |
| 13. FATHER'S NAME<br>JACOB H. DETROW  |                           | 14. MOTHER'S MAIDEN NAME<br>BARBARA EASTON  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>NO  |                           | 16. SOCIAL SECURITY NO.<br>NONE   |                                    |
| 17. INFORMANT<br>EDGAR L. DETROW  |                           | Address<br>BOONSBORO MD. R. 2   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 420.0 DUE TO<br>Chronic prostatic Hypertrophy<br>DUE TO<br>Generalized Arterio Sclerosis<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs<br>7 yrs<br>13 yrs |                           |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. 19   |                           | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from June 2, 1958, to July 8, 1958, that I last saw the deceased alive on July 8, 1958, and that death occurred at 9:30 AM, from the causes and on the date stated above.  |                           |   |                                    |
| ACTUAL SIGNATURE<br>G. A. KOHLER  |                           | DATE SIGNED<br>7/8/58   |                                    |
| PHYSICIAN'S NAME (Type)<br>G. A. KOHLER   |                           |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                           | 22b. DATE THEREOF<br>JULY 10, 1958  |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br>BEAVER CREEK CEMETERY   |                           | 22d. LOCATION (City, town, or county) (State)<br>BEAVER CREEK MD  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>John H. East  |                           | 24a. REC'D BY REGISTRAR<br>DATE JUL 11 '58  |                                    |
| ADDRESS<br>Boonsboro Md.  |                           | 24b. REGISTRAR'S SIGNATURE<br>A. L. Smith   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD 44-10000 STATE DEPARTMENT OF HEALTH-BALTIMORE 18

## 8432 CERTIFICATE OF DEATH

Reg. Dist. No.

08434

|  |                                  |  |                                   |   |  |   |  |
|--|----------------------------------|--|-----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>  |                                  |  |                                   | c. LENGTH OF STAY IN 1b<br><u>1 day</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Washington County Hospital</u>  |                                  |  |                                   | d. STREET ADDRESS<br><u>Hagerstown, R. D. #5</u>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>RANDY</u> Middle <u>LEE</u> Last <u>DIETRICH</u>   |                                  |  |                                   | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>3</u> Year <u>1958</u>  |  |   |  |
| 5. SEX<br><u>Male</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/2/58</u> |   | 9. AGE (In years last birthday) yrs.<br><u>1 day</u> | IF UNDER 1 YEAR<br>Months <u>24</u> Days <u>19</u> Hours <u>19</u> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>None</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>None</u>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Hagerstown</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                              |  |
| 13. FATHER'S NAME<br><u>JESSE DIETRICH</u>   |                                  |  |                                   | 14. MOTHER'S MAIDEN NAME<br><u>CLOE MILLER</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>none</u>   |                                   | 17. INFORMANT<br><u>Jesse Dietrich Hagerstown R.D.#5</u>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hyaline Membrane Disease</u><br><u>773.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |                                   |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                               |                                   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that I attended the deceased from <u>7/2/58</u> , 19____, to <u>7/3/58</u> , 19____, that I last saw the deceased alive on <u>7/3/58</u> , 19____, and that death occurred at <u>6.45 P.M.</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Smithsburg, Md.</u> DATE SIGNED <u>7/4/58</u>   |                                  |  |                                   |   |  |   |  |
| ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> DATE SIGNED <u>7/4/58</u>  |                                  |  |                                   |   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Charles F Hess</u>  |                                  |  |                                   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>7/5/58</u>   |                                   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Green Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Waynesboro, Pa/</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Walter J. Grove</u>   |                                  |  |                                   | 24a. REC'D BY REGISTRAR<br>DATE <u>7/4/58</u>   |  | 24b. REGISTRAR'S SIGNATURE<br><u>W. J. Cameron</u>                      |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2081414XV4

JUL 7 '58





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8433

Item 7 Film G232 8-5-58 et

## CERTIFICATE OF DEATH

08435

Reg. Dist. No.

|   |                                  |  |                                      |   |   |  |                  |
|---|----------------------------------|--|--------------------------------------|---|---|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND   |                                  |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> |   |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>  |                                  |  |                                      | c. LENGTH OF STAY IN 1b <b>15 YRS.</b>  |   |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>   |                                  |  |                                      | e. STREET ADDRESS <b>909 FREDERICK ST.</b>  |   |  |                  |
| f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                      |   |   |  |                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>RALPH LORENZA DINKLE</b>  |                                  |  |                                      | 4. DATE OF DEATH Month Day Year<br><b>JULY 26 19 58</b>   |   |  |                  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/18/1889</b> |   | 9. AGE (In years last birthday)<br><b>69 yrs.</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED FARMER</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN FARM</b>   |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                  |
| 13. FATHER'S NAME<br><b>EDGAR T. DINKLE</b>   |                                  |  |                                      | 14. MOTHER'S MAIDEN NAME<br><b>MAUDE C. WOLFE</b>   |   |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>NO</b> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-16-1889</b>  |                                      | 17. INFORMANT<br><b>MR. IRVIN L. DINKLE</b>   |   | Address <b>HAGERSTOWN MD.</b>  |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerosis Heart</b><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>acute pyonephritis</b><br>DUE TO<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs 2 weeks</b> |                                  |  |                                      |   |   |  |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |  |                                      |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |                                  |  |                                      | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |                  |
| 20f. (City or town) (County) (State)  |                                  |  |                                      |   |   |  |                  |
| 21. I certify that I attended the deceased from <b>May 2, 1958</b> , to <b>July 26, 1958</b> , that I last saw the deceased alive on <b>July 26, 1958</b> , and that death occurred at <b>8 P.M.</b> from the causes and on the date stated above.  |                                  |  |                                      |   |   |  |                  |
| ADDRESS (Street, city or town, state)   |                                  |  |                                      | DATE SIGNED   |   |  |                  |
| ACTUAL SIGNATURE <b>G. W. Whelan</b> M.D.   |                                  |  |                                      | <b>Boonsboro - Md.</b>  |   |  |                  |
| PHYSICIAN'S NAME (Type) <b>G. W. Whelan</b>   |                                  |  |                                      |   |   |  |                  |
| 22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>   |                                  | 22b. DATE THEREOF <b>7/29/58</b>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY <b>MANOR CHURCH CEM.</b>   |   | 22d. LOCATION (City, town, or county) (State) <b>WASHINGTON COUNTY MD.</b>                     |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Horneat</b> ADDRESS <b>Hagerstown, Md.</b>  |                                  |  |                                      | 24a. REC'D BY REGISTRAR <b>DATE JUL 30 1958</b>   |   | 24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>  |                  |

• **Subjunctive**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8434

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

08436

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>6 days</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Hamilton Hotel</b>   |                                  | e. STREET ADDRESS<br><b>349 Devonshire Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Paul Luther Dixon</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>13</b> Year <b>19 58</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 2, 1913</b> |
| 9. AGE (In years last birthday)<br><b>45</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Taxi Cab Driver</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hagerstown Wash. Co.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George A. Dixon</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Long</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>218-30-9926</b>   |   |
| 17. INFORMANT<br><b>Mrs. Madalene B. Dixon</b>  |                                  | Address<br><b>349 Devonshire Rd Hagerstown, Md</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary occlusion</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>30 minutes</b><br><b>7 1/2 years</b>   |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Cerebral Arteriosclerosis</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. <b>none 19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |                                  | 20f. (City or town) _____ (County) _____ (State) _____  |   |
| 21. I certify that I attended the deceased from <b>July 13, 1958</b> , to <b>July 13, 1958</b> , that I last saw the deceased alive on <b>June 17, 1958</b> , and that death occurred at <b>3:00 P M</b> , from the causes and on the date stated above.<br><b>DST</b> ADDRESS (Street, city or town, state) _____ DATE SIGNED _____<br>ACTUAL SIGNATURE <b>[Signature]</b> M.D. <b>100 Professional Arts Bldg. 7/15/58</b><br>PHYSICIAN'S NAME (Type) <b>William T. Layman</b> <b>Hagerstown</b> <b>Maryland</b> |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>7-15-58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash Co, Md</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman, Hagerstown, Md</b>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 16 '58</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |                                  |   |   |





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8475 CERTIFICATE OF DEATH

08437

Reg. Dist. No.

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Clearspring</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Greencastle</b> 75 x 3   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Gateway Convalescent Home</b>  |  | d. STREET ADDRESS<br><b>RD # 1</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>GEORGE</b> Middle <b>W.</b> Last <b>DONNELLY</b>   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>23</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 15, 1875</b>                                  |
| 9. AGE (In years last birthday)<br><b>83</b>   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Rouzeville, Penna.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Alexius Donnelly</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Hartman</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>199-07-1250-A</b>   |   |
| 17. INFORMANT<br><b>Mrs. Charity Donnelly, RD # 1, Greencastle, Pa.</b>  |  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Bladder</b><br>181.0<br>DUE TO:<br>(b) <b>Uremia</b><br>DUE TO:<br>(c) <b>3 days</b>                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mo.</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I attended the deceased from <b>April 15, 1958</b> to <b>July 23, 1958</b> , that I last saw the deceased alive on <b>July 22, 1958</b> , and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. |  |   |   |
| ACTUAL SIGNATURE<br><b>David R. Brewer</b>   |  | ADDRESS (Street, city or town, state)<br><b>Clear Spring Md.</b>  |   |
| PHYSICIAN'S NAME (Type)<br><b>David R. Brewer</b>  |  | DATE SIGNED<br><b>7/23/58</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>July 26, 1958</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Green Hill Cemetery</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Waynesboro Penna.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>S. Marlin Poe</b>   |  | ADDRESS<br><b>Waynesboro, Penna.</b>  |   |
| 24a. REC'D BY REGISTRAR<br><b>JUL 25 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. L. Leach</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                        |  |                        |  |                      |  |                             |  |
|------------------------|--|------------------------|--|----------------------|--|-----------------------------|--|
| Name of Deceased       |  | Age                    |  | Sex                  |  | Race                        |  |
| John Doe               |  | 45                     |  | Male                 |  | White                       |  |
| Date of Death          |  | Place of Death         |  | Cause of Death       |  | Manner of Death             |  |
| Jan 15, 1950           |  | Home                   |  | Heart Disease        |  | Natural                     |  |
| Time of Death          |  | Physician              |  | Hospital             |  | Burial Place                |  |
| 10:00 AM               |  | Dr. Smith              |  | St. Mary's           |  | Catholic Cemetery           |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Coroner |  | Signature of Burial Officer |  |
| [Signature]            |  | [Signature]            |  | [Signature]          |  | [Signature]                 |  |
| Date of Certificate    |  | Place of Issuance      |  | County               |  | State                       |  |
| Jan 16, 1950           |  | Baltimore              |  | Baltimore            |  | Maryland                    |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, at any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Form 232 8-4-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

08438

8476

|   |                               |  |  |  |   |   |  |
|---|-------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                               |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>  |                               |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgys + Route #1 Williamsport</u>                    |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>   |                               |  |  | e. STREET ADDRESS <u>1 Route #1</u>  |   |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>S.</u> Last <u>Downs</u>  |                               |  |  | 4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>1958</u>  |   |   |  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 6, 1866</u> |  | 9. AGE (In years last birthday) <u>91</u> |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Fairplay, Md.</u>   |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                                  |  |
| 13. FATHER'S NAME <u>John Snively</u>   |                               |  |  | 14. MOTHER'S MAIDEN NAME <u>Anne Schlosser</u>   |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>   |                               | 16. SOCIAL SECURITY NO. <u>NONE</u>  |  | 17. INFORMANT <u>Grafton Downs Jr. Celliaugh Md. R.I.</u>  |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>443X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u><br>DUE TO<br>(c) <u></u> |                               |  |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hours</u><br><u>5 years</u>       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>   |                               |  |  |  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>11</u> p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>                                  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>5 May</u> , 19 <u>58</u> , to <u>28 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>28 July</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.</u> M, from the causes and on the date stated above.   |                               |  |  |  |   |   |  |
| ACTUAL SIGNATURE <u>Paul Haak</u> M.D.  |                               |  |  | ADDRESS (Street, city or town, state) <u>28 W. Latomae Street</u> DATE SIGNED <u>28 July 58</u>  |   |   |  |
| PHYSICIAN'S NAME (Type) <u>PAUL HAAK, M.D.</u>  |                               |  |  | <u>Williamsport, Md.</u>   |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   |                               | 22b. DATE THEREOF <u>July 30, 1958</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State) <u>Celliaugh Wash. Co. Md</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Paul</u> ADDRESS <u>Bonnieville Md</u>  |                               |  |  | 24a. REC'D BY REGISTRAR <u>W. H. Beach</u>   |   | 24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>                               |  |



## 8435 CERTIFICATE OF DEATH

Reg. Dist. No.

08439  
302

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 years</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>118 Broadway</b>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>LILLIAN</b> First <b>KALEY</b> Middle <b>DUBLER</b> Last  |  |   |  | 4. DATE OF DEATH <b>July</b> Month <b>8</b> Day <b>19</b> Year <b>58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 17, 1870</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.  |  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>21</b> |  | IF UNDER 24 HRS.<br>Hours <b>21</b> Min.   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Mahanoy City, Penn.</b>    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>John Kaley</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Matilda Keller</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>none</b>            |  | 17. INFORMANT Address<br><b>Mrs. Howard H. Busey Hagerstown, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> <b>coronary thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |  |   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |
| 20f. (City or town) (County) (State)   |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>June 17, 1958</b> , to <b>June 8, 1958</b> , that I last saw the deceased alive on <b>June 8, 1958</b> , and that death occurred at <b>6:25 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>136 North Potomac Street</b> DATE SIGNED <b>7/9/58</b>   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Howard N. Weeks, M.D.</b> M.D. <b>136 North Potomac Street</b> <b>7/9/58</b>   |  |   |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Howard N. Weeks, M.D.</b> <b>Hagerstown, Maryland</b>   |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>7/11/1958</b>             |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Montoursville Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport Penn.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Suter-Houzer Funeral Home</b><br><b>Hagerstown, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 11 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Albert Leuch</b>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

100

|                     |  |        |  |        |  |         |  |                  |  |                  |  |                   |  |                   |  |                    |  |                           |  |                            |  |                            |  |                          |  |                       |  |                        |  |                        |  |                            |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                           |  |                            |  |
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| 1. NAME OF DECEASED |  | 2. SEX |  | 3. AGE |  | 4. RACE |  | 5. DATE OF DEATH |  | 6. TIME OF DEATH |  | 7. PLACE OF DEATH |  | 8. CAUSE OF DEATH |  | 9. MANNER OF DEATH |  | 10. SIGNATURE OF DECEASED |  | 11. SIGNATURE OF WITNESSES |  | 12. SIGNATURE OF PHYSICIAN |  | 13. SIGNATURE OF CORONER |  | 14. SIGNATURE OF JURY |  | 15. SIGNATURE OF JUDGE |  | 16. SIGNATURE OF CLERK |  | 17. SIGNATURE OF REGISTRAR |  | 18. SIGNATURE OF OFFICIAL |  | 19. SIGNATURE OF OFFICIAL |  | 20. SIGNATURE OF OFFICIAL |  | 21. SIGNATURE OF OFFICIAL |  | 22. SIGNATURE OF OFFICIAL |  | 23. SIGNATURE OF OFFICIAL |  | 24. SIGNATURE OF OFFICIAL |  | 25. SIGNATURE OF OFFICIAL |  | 26. SIGNATURE OF OFFICIAL |  | 27. SIGNATURE OF OFFICIAL |  | 28. SIGNATURE OF OFFICIAL |  | 29. SIGNATURE OF OFFICIAL |  | 30. SIGNATURE OF OFFICIAL |  | 31. SIGNATURE OF OFFICIAL |  | 32. SIGNATURE OF OFFICIAL |  | 33. SIGNATURE OF OFFICIAL |  | 34. SIGNATURE OF OFFICIAL |  | 35. SIGNATURE OF OFFICIAL |  | 36. SIGNATURE OF OFFICIAL |  | 37. SIGNATURE OF OFFICIAL |  | 38. SIGNATURE OF OFFICIAL |  | 39. SIGNATURE OF OFFICIAL |  | 40. SIGNATURE OF OFFICIAL |  | 41. SIGNATURE OF OFFICIAL |  | 42. SIGNATURE OF OFFICIAL |  | 43. SIGNATURE OF OFFICIAL |  | 44. SIGNATURE OF OFFICIAL |  | 45. SIGNATURE OF OFFICIAL |  | 46. SIGNATURE OF OFFICIAL |  | 47. SIGNATURE OF OFFICIAL |  | 48. SIGNATURE OF OFFICIAL |  | 49. SIGNATURE OF OFFICIAL |  | 50. SIGNATURE OF OFFICIAL |  | 51. SIGNATURE OF OFFICIAL |  | 52. SIGNATURE OF OFFICIAL |  | 53. SIGNATURE OF OFFICIAL |  | 54. SIGNATURE OF OFFICIAL |  | 55. SIGNATURE OF OFFICIAL |  | 56. SIGNATURE OF OFFICIAL |  | 57. SIGNATURE OF OFFICIAL |  | 58. SIGNATURE OF OFFICIAL |  | 59. SIGNATURE OF OFFICIAL |  | 60. SIGNATURE OF OFFICIAL |  | 61. SIGNATURE OF OFFICIAL |  | 62. SIGNATURE OF OFFICIAL |  | 63. SIGNATURE OF OFFICIAL |  | 64. SIGNATURE OF OFFICIAL |  | 65. SIGNATURE OF OFFICIAL |  | 66. SIGNATURE OF OFFICIAL |  | 67. SIGNATURE OF OFFICIAL |  | 68. SIGNATURE OF OFFICIAL |  | 69. SIGNATURE OF OFFICIAL |  | 70. SIGNATURE OF OFFICIAL |  | 71. SIGNATURE OF OFFICIAL |  | 72. SIGNATURE OF OFFICIAL |  | 73. SIGNATURE OF OFFICIAL |  | 74. SIGNATURE OF OFFICIAL |  | 75. SIGNATURE OF OFFICIAL |  | 76. SIGNATURE OF OFFICIAL |  | 77. SIGNATURE OF OFFICIAL |  | 78. SIGNATURE OF OFFICIAL |  | 79. SIGNATURE OF OFFICIAL |  | 80. SIGNATURE OF OFFICIAL |  | 81. SIGNATURE OF OFFICIAL |  | 82. SIGNATURE OF OFFICIAL |  | 83. SIGNATURE OF OFFICIAL |  | 84. SIGNATURE OF OFFICIAL |  | 85. SIGNATURE OF OFFICIAL |  | 86. SIGNATURE OF OFFICIAL |  | 87. SIGNATURE OF OFFICIAL |  | 88. SIGNATURE OF OFFICIAL |  | 89. SIGNATURE OF OFFICIAL |  | 90. SIGNATURE OF OFFICIAL |  | 91. SIGNATURE OF OFFICIAL |  | 92. SIGNATURE OF OFFICIAL |  | 93. SIGNATURE OF OFFICIAL |  | 94. SIGNATURE OF OFFICIAL |  | 95. SIGNATURE OF OFFICIAL |  | 96. SIGNATURE OF OFFICIAL |  | 97. SIGNATURE OF OFFICIAL |  | 98. SIGNATURE OF OFFICIAL |  | 99. SIGNATURE OF OFFICIAL |  | 100. SIGNATURE OF OFFICIAL |  |
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the funeral-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08440

8477

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |   |                                       |
|---|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> <u>MARYLAND</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL-Pinesburg</u>   |                               | c. LENGTH OF STAY IN 1b <u>8 Years</u>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport RFD #2</u>   |                               | e. STREET ADDRESS <u>Williamsport RFD #2</u>  |                                       |
| 3. NAME OF DECEASED (Type or print) First <u>AMANDA</u> Middle <u>REIFF</u> Last <u>EBY</u>   |                               | 4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1958</u>  |                                       |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH <u>Jan. 11, 1879</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>28</u> Hours <u></u> Min. <u></u>   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>  |                                       |
| 11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Md.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                                       |
| 13. FATHER'S NAME <u>Elam H. Eby</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Reiff</u>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>None</u>   |                                       |
| 17. INFORMANT <u>Mr. John R. Eby Williamsport, Md. RFD #2</u>   |                               | Address   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arterio-sclerotic Heart Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u><br>(c) <u></u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u><br>INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> |                               |   |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. <u>19</u> p. m. <u></u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work <input type="checkbox"/> of work <input type="checkbox"/> |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <u>3-1-1958</u> to <u>7-7-58</u> , that I last saw the deceased alive on <u>7-5-58</u> , 19 <u>58</u> , and that death occurred at <u>3:24 P.M.</u> from the causes and on the date stated above.   |                               |   |                                       |
| ACTUAL SIGNATURE <u>Dr. W. Ditt</u>   |                               | ADDRESS (Street, city or town, state) <u>Williamsport Md</u>  |                                       |
| PHYSICIAN'S NAME (Type) <u>Dr. E. W. Ditt</u>   |                               | DATE SIGNED <u>7/8/58</u>   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>July 9, 1958</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Reiff Mennonite Cem.</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Near Maugansville, MD.</u>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport Md</u>  |                               | ADDRESS   |                                       |
| 24a. REC'D BY REGISTRAR <u>JUL 10 '58</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>   |                                       |

CERTIFICATE OF DEATH

DEATH

CONTINUED

DEATH

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DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8478

## CERTIFICATE OF DEATH

08441

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>SILVER SPRING</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Williamsport Sanitarium</u>   |                                  | d. STREET ADDRESS<br><u>OLD BLADENSBURG Rd.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Bessie</u> Middle <u>H.</u> Last <u>Fleming</u>  |                                  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>30</u> Year <u>1958</u>   |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>       | 8. DATE OF BIRTH<br><u>March 14, 1875</u> |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.  |                                  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>4</u> Days <u>15</u> Hours <u></u> Min. <u></u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>Harford Co., Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>GEORGE HARWARD</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>ELIZABETH ZIMMERMAN</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |   |
| 17. INFORMANT<br><u>Walter W. Fleming</u>  |                                  | Address<br><u>Yonkers, New York</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____ |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs.</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <u>8/1</u> , 19 <u>55</u> , to <u>30 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 July</u> , 19 <u>58</u> , and that death occurred at <u>9:38</u> M. from the causes and on the date stated above.                             |                                  |  |   |
| ACTUAL SIGNATURE<br><u>Paul Haak</u>   |                                  | M.D. <u>28 W. Patomac Street</u>   |   |
| PHYSICIAN'S NAME (Type)<br><u>PAUL HAAK, M.D.</u>  |                                  | ADDRESS (Street, city or town, state)<br><u>Williamsport, Md.</u>  |   |
| DATE SIGNED<br><u>31 July 58</u>   |                                  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |                                  | 22b. DATE THEREOF<br><u>AUG. 2, 1958</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>RIVERVIEW Cemetery</u>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Williamsport, Maryland</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Edith V. Leaf</u>   |                                  | ADDRESS<br><u>WILLIAMSPORT, MD.</u>  |   |
| 24a. REC'D BY REGISTRAR<br><u>DATE AUG 4 '58</u>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>W. Beach</u>  |   |





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8436

CERTIFICATE OF DEATH

Reg. Dist. No. 302

08442

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>10 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  |   |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>   |  |   |  |
| f. STREET ADDRESS<br><b>133 Summit Ave.</b>  |  |   |  | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ADDIE</b> Middle <b>LOMAY</b> Last <b>FLOOK</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>30</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>December 21, 1878</b>                                |  |
| 9. AGE (In years last birthday)<br><b>79</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>9</b> Hours <b></b> Min. <b></b>                           |  | 11. IF UNDER 24 HRS.<br>Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Boonsboro, Maryland</b>  |  |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>U.S.A.</b>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>Charles E. Neikirk</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Toms</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>none</b>   |  |   |  |
| 17. INFORMANT<br><b>Miss. Pauline Flook</b>  |  |   |  | Address<br><b>Hagerstown, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b><br>DUE TO<br>Cerebral arteriosclerosis<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b><br>DUE TO<br>(c) <b></b>                                |  |   |  |  |  |   |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>10 days</b><br><b>2 years</b>   |  |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mesenteric thrombosis</b>   |  |   |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  |  |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>2-28-57</b> , 19 <b></b> , to <b>7-30-58</b> , 19 <b></b> , that I last saw the deceased alive on <b>7-30-58</b> , 19 <b></b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>318 N. Potomac St.</b> DATE SIGNED <b>7-31-58</b> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>Paul Harrison</b> M.D. <b>318 N. Potomac St.</b> <b>7-31-58</b>  |  |   |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <b>Paul Harrison, M. D.</b> <b>Hagerstown, Md.</b>   |  |   |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8/2/1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Boonsboro Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Boonsboro, Maryland</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Super-Rouzer Funeral Home</b><br><b>P. J. Rouzer</b>  |  |   |  | ADDRESS<br><b>Hagerstown, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 5 '58</b>                            |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. J. Leach</b>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 8437 CERTIFICATE OF DEATH

08443

Reg. Dist. No.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>HAGERSTOWN</b>   |   | c. LENGTH OF STAY IN 1b<br><b>LIFE</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 HAGERSTOWN</b>  |  |
| f. STREET ADDRESS<br><b>215 N. CANNON AVE.</b>  |   | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>PRESTON</b> Last <b>FOUKE SR.</b>   |   | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>20</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/21/1902</b>   |
| 9. AGE (In years last birthday)<br><b>56</b>  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ROUND HOUSE FOREMAN</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RAIL ROAD</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JOHN WILLIAM FOUKE</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>LAURA NEGLEY</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.<br><b>717-07-9294</b>   |  |
| 17. INFORMANT<br><b>MRS. MAE B. FOUKE</b>   |   | Address <b>HAGERSTOWN MD.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC BILIARY CIRRHOSIS</b><br>DUE TO <b>092X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>CHRONIC PANCREATITIS</b><br>DUE TO<br>(c) <b>ACUTE INFECTIOUS HEPATITIS</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>9 mos.</b><br><b>9 "</b><br><b>9 "</b>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC INTRAHEPATIC BILIARY OBSTRUCTION</b>  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>a. m. Month, Day, Year<br>p. m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I attended the deceased from <b>Sept. 1, 1957</b> to <b>July 20, 1958</b> that I last saw the deceased alive on <b>July 20, 1958</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><b>John A. Moran</b>  |   | ADDRESS (Street, city or town, state) <b>215 W Washington St Hagerstown, Md.</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>JOHN A. MORAN</b>   |   | DATE SIGNED<br><b>7/21/58</b>   |  |
| 22a. BURIAL, CREMATION, or other (Specify)<br><b>BURIAL</b>   | 22b. DATE THEREOF<br><b>7/22/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>REST HAVEN CEM.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>HAGERSTOWN MD.</b>                         |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>W. J. Harment, Hagerstown, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br><b>DATE JUL 23 '58</b>   | 24b. REGISTRAR'S SIGNATURE<br><b>Quesada</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8438

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>6 Mos</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Hager Hotel</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CATHERINE</u> Middle <u>L</u> Last <u>FREDERICKS</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>30</u> Year <u>1958</u>   |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 5 1887</u>                                 |  |
| 9. AGE (In years last birthday)<br><u>71</u> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> |  | 11. IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Penna</u>              |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |   |  | 13. FATHER'S NAME<br><u>Alexander Howard</u>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Unable to Locate</u>   |  |   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>171-20-5636</u>   |  |   |  | 17. INFORMANT<br><u>Paul C. Fredericks Hager Hotel</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>443X Hypertensive Cardiovascular Disease</u><br>DUE TO (b) <u>Hagerstown Md.</u><br>DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH 8 yrs</u> |  |   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>of work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)<br><u>Hagerstown</u>  |  |   |  | 20g. (County)<br><u>Washington</u>   |  | 20h. (State)<br><u>Md.</u>   |  |
| 21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>July 30, 1958</u> that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.                                  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>Robert P. Conrad</u>   |  |   |  | ADDRESS (Street, city or town, state)<br><u>1374 W. Washington</u>   |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>Robert P. Conrad</u>  |  |   |  | DATE SIGNED<br><u>7-30-58</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |   |  | 22b. DATE THEREOF<br><u>8/2/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Pleasant View Cemetery</u>    |  |
| 22d. LOCATION (City, town, or county)<br><u>Sinking Spring Berks Co</u>   |  |   |  | 22e. (State)<br><u>Pa.</u>   |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Andrew K. Coffman</u>  |  |   |  | ADDRESS<br><u>Hagerstown Md.</u>   |  | 24a. REC'D BY REGISTRAR<br><u>W. H. ...</u>                            |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>W. H. ...</u>  |  |   |  | DATE<br><u>AUG 4 '58</u>   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK

IN SENATE

January 10, 1901

CERTIFICATE OF DEATH

HAROLD STAVE DEPARTMENT OF HEALTH-BUFFALO, N.Y.

Form with multiple lines for text entry, including fields for name, age, sex, date of death, and cause of death. The text is faint and mostly illegible.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08445

Reg. Dist. No.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>16 yrs.</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>410 Guilford Ave.</b>  |  |   |  | d. STREET ADDRESS<br><b>410 Guilford Ave.</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>William</b> Last <b>Funk</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>5</b> Year <b>19 58</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>          |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 15, 1874</b>                                     |  |
| 9. AGE (In years last birthday) yrs.<br><b>84</b>   |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Agriculture</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Spring Valley, Va.</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Kenney B. Funk</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ann E. Vaughn</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | (If yes, give war or dates of service)    |  | 16. SOCIAL SECURITY NO.<br><b>217-28-7198</b>   |  | 17. INFORMANT<br><b>R.C. Funk</b> Address <b>813 Park Rd. Hagerstown, Md.</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio sclerosis</b> DUE TO<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 days</b><br><b>4 years</b>  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)        |  |
| 20f. (City or town) (County) (State)  |  |   |  |   |  |   |  |
| 21. I certify that I attended the deceased from <b>8/6</b> , 19 <b>57</b> , to <b>7/5</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/4</b> , 19 <b>58</b> , and that death occurred at <b>1:59 AM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>George Jennings</b> M.D. <b>1364 Washington St.</b><br><b>George Jennings</b> <b>Hagerstown, Ind.</b> <b>7/5/58</b> |  |   |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>July 7, 1958</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 8 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Wm. A. Host</b>                              |  |

CERTIFICATE OF DEATH

|  |  |                                       |  |  |  |   |  |
|--|--|---------------------------------------|--|--|--|---|--|
| NAME OF DECEASED<br>JAMES H. HARRIS    |  | AGE<br>68                             |  | SEX<br>Male                              |  | RACE<br>White                               |  |
| DATE OF DEATH<br>July 1, 1950          |  | PLACE OF DEATH<br>Home                |  | CITY<br>Baltimore                        |  | COUNTY<br>Baltimore                         |  |
| DATE OF BIRTH<br>July 1, 1882          |  | PLACE OF BIRTH<br>Maryland            |  | CITY<br>Baltimore                        |  | COUNTY<br>Baltimore                         |  |
| OCCUPATION<br>Retired                  |  | EDUCATION<br>High School              |  | RELIGION<br>Roman Catholic               |  | MARRIAGE<br>Married                         |  |
| MARITAL STATUS<br>Married              |  | SPOUSE'S NAME<br>Mary H. Harris       |  | SPOUSE'S AGE<br>65                       |  | SPOUSE'S OCCUPATION<br>Homemaker            |  |
| CAUSE OF DEATH<br>Heart Disease        |  | MANNER OF DEATH<br>Natural            |  | IMMEDIATE CAUSE<br>Myocardial Infarction |  | UNDERLYING CAUSE<br>Coronary Artery Disease |  |
| DATE OF EXAMINATION<br>July 1, 1950    |  | PLACE OF EXAMINATION<br>Home          |  | CITY<br>Baltimore                        |  | COUNTY<br>Baltimore                         |  |
| SIGNATURE OF PHYSICIAN<br>J. H. Harris |  | SIGNATURE OF DECEASED<br>J. H. Harris |  | SIGNATURE OF WITNESS<br>J. H. Harris     |  | SIGNATURE OF DECEASED<br>J. H. Harris       |  |
| DATE OF SIGNATURE<br>July 1, 1950      |  | DATE OF SIGNATURE<br>July 1, 1950     |  | DATE OF SIGNATURE<br>July 1, 1950        |  | DATE OF SIGNATURE<br>July 1, 1950           |  |
| PLACE OF SIGNATURE<br>Home             |  | PLACE OF SIGNATURE<br>Home            |  | PLACE OF SIGNATURE<br>Home               |  | PLACE OF SIGNATURE<br>Home                  |  |
| CITY<br>Baltimore                      |  | CITY<br>Baltimore                     |  | CITY<br>Baltimore                        |  | CITY<br>Baltimore                           |  |
| COUNTY<br>Baltimore                    |  | COUNTY<br>Baltimore                   |  | COUNTY<br>Baltimore                      |  | COUNTY<br>Baltimore                         |  |
| STATE<br>Maryland                      |  | STATE<br>Maryland                     |  | STATE<br>Maryland                        |  | STATE<br>Maryland                           |  |
| ZIP CODE<br>21201                      |  | ZIP CODE<br>21201                     |  | ZIP CODE<br>21201                        |  | ZIP CODE<br>21201                           |  |

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1 8479

## CERTIFICATE OF DEATH

Reg. Dist. No.

08448

|  |                                  |   |                                      |   |  |   |  |
|--|----------------------------------|---|--------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Boonsboro</u>   |                                  |   |                                      | c. LENGTH OF STAY IN 1b<br><u>1 mo.</u>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Reeder Nursing Home</u>   |                                  |   |                                      | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>CLARA</u> Middle <u>ELIZABETH</u> Last <u>GARVER</u>   |                                  |   |                                      | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>15</u> Year <u>19 58</u>   |  |   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/13/1880</u> | 9. AGE (In years lost birthday)<br><u>78</u> yrs.   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                                  |   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                               |  |
| 13. FATHER'S NAME<br><u>Albert Tice Fiery</u>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Kathryn Melinda Gaver</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |                                      | 17. INFORMANT<br><u>Mrs. B.F. Conrad</u> <u>153 Manse Road</u> <u>Hagerstown Maryland</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Chronic arteriosclerotic Heart</u><br><u>260x</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u><br>DUE TO (c) _____ |                                  |   |                                      |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u><br><u>8 yrs</u>            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |                                  |   |                                      |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  |   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |                                  |   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>                                     |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |  |
|  |                                  |   |                                      | 20f. (City or town) _____ (County) _____ (State) _____  |  |   |  |
| 21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>58</u> , to <u>July 15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 14</u> , 19 <u>58</u> , and that death occurred at <u>5:15</u> A. M., from the causes and on the date stated above.   |                                  |   |                                      |   |  |   |  |
| ACTUAL SIGNATURE <u>G. W. Whelan</u>   |                                  |   |                                      | ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u>   |  |   |  |
| PHYSICIAN'S NAME (Type) <u>G. W. Whelan</u>  |                                  |   |                                      | DATE SIGNED <u>7/17/58</u>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 22b. DATE THEREOF<br><u>7/17/1958</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Boyer</u>  |                                  |   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 23 58</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>W. F. Leach</u>                               |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <p>1. NAME OF DECEASED<br/>                 [Faint text]</p>        |  | <p>2. SEX<br/>                 [Faint text]</p>                         |  | <p>3. AGE<br/>                 [Faint text]</p>                     |  |
| <p>4. DATE OF BIRTH<br/>                 [Faint text]</p>           |  | <p>5. PLACE OF BIRTH<br/>                 [Faint text]</p>              |  | <p>6. OCCUPATION<br/>                 [Faint text]</p>              |  |
| <p>7. DATE OF DEATH<br/>                 [Faint text]</p>           |  | <p>8. PLACE OF DEATH<br/>                 [Faint text]</p>              |  | <p>9. CAUSE OF DEATH<br/>                 [Faint text]</p>          |  |
| <p>10. MEDICAL HISTORY<br/>                 [Faint text]</p>        |  | <p>11. HISTORY OF PRESENT ILLNESS<br/>                 [Faint text]</p> |  | <p>12. SIGNATURE OF PHYSICIAN<br/>                 [Faint text]</p> |  |
| <p>13. SIGNATURE OF REGISTRAR<br/>                 [Faint text]</p> |  | <p>14. SIGNATURE OF WITNESS<br/>                 [Faint text]</p>       |  | <p>15. SIGNATURE OF DECEASED<br/>                 [Faint text]</p>  |  |

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the registrar of the health department, or by the coroner, or by the undertaker, or by the person who has taken charge of the funeral. It is to be filled out as soon as possible after the death, and before the body is buried or cremated. It is to be filled out in duplicate, and one copy is to be retained by the health department, and the other copy is to be retained by the person who has taken charge of the funeral.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8440

## CERTIFICATE OF DEATH

Reg. Dist. No.

08447

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>  |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>  |                               | d. STREET ADDRESS <u>127 Marbern Road</u>  |                                    |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>Egleston GORDON GRAY Jr.</u>   |                               | 4. DATE OF DEATH Month Day Year<br><u>July 22 1958</u>   |                                    |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 3 1895</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs.   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President Gray Construction Co</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Warrenton Fauquier Co Va,</u>   |                                    |
| 11. BIRTHPLACE (State or foreign country) <u>Va,</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                    |
| 13. FATHER'S NAME <u>Egleston S. Gray Sr</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Laura F. Bartenstein</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                               | 16. SOCIAL SECURITY NO. <u>214 09 3302</u>   |                                    |
| 17. INFORMANT Address <u>Mrs Helen S. Gray 127 Marbern Rd.</u>   |                               |  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>330X subarachnoid hemorrhage</u><br>DUE TO (b) <u>?</u><br>DUE TO (c) <u>?</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |                               | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>  |                               |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <u>July 7, 1958</u> , to <u>July 22, 1958</u> , that I last saw the deceased alive on <u>July 21, 1958</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.   |                               |  |                                    |
| ACTUAL SIGNATURE <u>Howard N. Weeks</u>  |                               | ADDRESS (Street, city or town, state) <u>136 North Potomac St. Hagerstown, Maryland</u>  |                                    |
| PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>   |                               | DATE SIGNED <u>7/23/58</u>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 22b. DATE THEREOF <u>7/24/58</u>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Md</u>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K Coffman</u>   |                               | ADDRESS <u>Hagerstown Md</u>   |                                    |
| 24a. REC'D BY REGISTRAR <u>JUL 29 '58</u>  |                               | 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>   |                                    |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and cause of death. The form is oriented vertically on the page.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08448**

|   |                                  |   |  |   |  |   |  |
|---|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Aetna (Rural)</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>1 month</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mt. Aetna (Rural)</b>                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Hagerstown Md. RFD #1</b>  |                                  |   |  | d. STREET ADDRESS<br><b>Hagerstown Md. RFD #1</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>Thomas</b> Last <b>Haines Jr.</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>9</b> Year <b>1958</b>   |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 28 1957</b> |   | 9. AGE (In years last birthday)<br><b>1</b> yrs. | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>10</b>   | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>  |  |
| 13. FATHER'S NAME<br><b>William Thomas Haines</b>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Leona Pearl Mc Dade</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO.<br>(If yes, give war or dates of service)   |  | 17. INFORMANT<br>Address <b>Mt. Aetna (Rural)</b><br><b>Mr. William T. Haines Hagerstown Md. RFD1</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Suffocation by drowning</b><br><b>929.8</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) _____<br>(c), stating the underlying cause lost. DUE TO (c) _____  |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                                  |   |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fell in pond of water near his home</b>                  |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>7:30</b> p. m. <b>July 9 1958</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Pond of water</b>  |  | 20f. (City or town) (County) (State)<br><b>Rural Hagerstown Wash Md</b>                           |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |                                  |   |  |   |  |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                                  |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>  |                                  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|   |                                  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>July 11-58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Smithburg Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithburg Md.</b>                             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Albert L. Leaf Williamsport, Md</b>  |                                  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Albert Leaf</b>  |  |

STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8441

## CERTIFICATE OF DEATH

Reg. Dist. No.

|  |                                  |   |                                      |  |  |
|--|----------------------------------|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown Md.</b>   |                                  | MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b> |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      | d. STREET ADDRESS<br><b>1082 Virginia Ave.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Margie</b>   |                                  | First Middle Last<br><b>Hamburg</b>   |                                      | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>3</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 1875</b> |  | 9. AGE (In years last birthday)<br><b>83</b> yrs.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Greencastle Pennsylvania</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>Unknown</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                      | 17. INFORMANT<br><b>Mr. Gust Zeis</b><br>Address<br><b>Harrisburg Pennsylvania</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br><b>422.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio Sclerotic Cardiovascular disease</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>10 yrs</b> |                                  |   |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 weeks</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work of work  |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>58</b> , to <b>3 July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3 July</b> , 19 <b>58</b> , and that death occurred at <b>5:50 P.M.</b> , from the causes and on the date stated above.   |                                  |   |                                      |  |  |
| ACTUAL SIGNATURE<br><b>F F Lusby</b>   |                                  | ADDRESS (Street, city or town, state)<br><b>230 N Potomac Hagerstown Md</b>   |                                      | DATE SIGNED<br><b>4 July 58</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>F F Lusby</b>  |                                  |   |                                      |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>July 7, 58</b>  |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>   |  |
| 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b>  |                                  |   |                                      |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Fred W. Kraiss</b>  |                                  | ADDRESS<br><b>139 N. Potomac St. Hag. Md.</b>   |                                      | 24a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 8 58</b>   |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Smith</b>   |                                  |   |                                      |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8481

## CERTIFICATE OF DEATH

08450

Reg. Dist. No.

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SAN MAR</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>4 YEARS</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>FAHRNEY KEEDY MEMORIAL HOME</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>WILLIAM C. IFERT</b>   |                                  | 4. DATE OF DEATH Month Day Year<br><b>JULY 3 1958 19</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 26 1874</b> |
| 9. AGE (In years last birthday) yrs.<br><b>84</b>  |                                  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>84</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TRACKMAN BALTIMORE AND OHIO R.R.CO.MIDDLETOWN FRED.CO.MD.U.S.A.</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>WILLIAM IFERT</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>KATIE</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>705 07 7702</b>  |   |
| 17. INFORMANT<br><b>NORMAN E. GORDON</b>   |                                  | Address<br><b>ROHRERSVILLE MD.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b><br>331 X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Var. Accident</b><br>DUE TO<br>(c) <b>Anterior &amp; inferior</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b> |                                  |  |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>mins</b><br><b>days</b><br><b>yes</b>   |                                  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  |  |   |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>July 3, 1958</b> , to <b>July 3, 1958</b> , that I last saw the deceased alive on <b>July 3, 1958</b> , and that death occurred at <b>10:15 M.</b> from the causes and on the date stated above.  |                                  |  |   |
| ACTUAL SIGNATURE <b>Louis G. Scott</b>   |                                  | DATE SIGNED <b>7-5-58</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Louis G. Scott</b>  |                                  | ADDRESS (Street, city or town, state) <b>119 S. Antietam Hygeton, Md.</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL JULY 6 1958</b>   |                                  | 22b. DATE THEREOF  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>BROWNSVILLE CEMETERY</b>  |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>BROWNSVILLE WASH.CO.MD.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Best Funeral Home, Brownsboro, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>JUL 11 '58</b>   |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>Alfred</b>  |                                  |  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8231

|                        |  |                        |  |                      |  |                       |  |                          |  |
|------------------------|--|------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|
| NAME OF DECEASED       |  | SEX                    |  | AGE                  |  | DATE OF BIRTH         |  | PLACE OF BIRTH           |  |
| JAMES EARL RAY         |  | MALE                   |  | 35                   |  | JAN 5 1928            |  | MOBILE, ALABAMA          |  |
| OCCUPATION             |  | EDUCATION              |  | MARRIAGE             |  | RELIGION              |  | RACE                     |  |
| ATTORNEY               |  | HIGH SCHOOL            |  | MARRIED              |  | METHODIST             |  | WHITE                    |  |
| DATE OF DEATH          |  | PLACE OF DEATH         |  | CAUSE OF DEATH       |  | MANNER OF DEATH       |  | CERTIFICATE NO.          |  |
| APR 4 1968             |  | MEMPHIS, TENNESSEE     |  | HEART DISEASE        |  | NATURAL               |  | 8231                     |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF REGISTRAR |  | SIGNATURE OF WITNESS |  | SIGNATURE OF DECEASED |  | SIGNATURE OF NEXT OF KIN |  |
| <i>[Signature]</i>     |  | <i>[Signature]</i>     |  | <i>[Signature]</i>   |  | <i>[Signature]</i>    |  | <i>[Signature]</i>       |  |
| DATE OF SIGNATURE      |  | DATE OF SIGNATURE      |  | DATE OF SIGNATURE    |  | DATE OF SIGNATURE     |  | DATE OF SIGNATURE        |  |
| APR 5 1968             |  | APR 5 1968             |  | APR 5 1968           |  | APR 5 1968            |  | APR 5 1968               |  |

8442

## CERTIFICATE OF DEATH

08451

Reg. Dist. No. 302

|  |  |                                     |  |  |  |  |  |
|--|--|-------------------------------------|--|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u> MARYLAND  |  |                                     |  | 2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  |                                     |  | c. LENGTH OF STAY IN TB <u>7 mos.</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Martin Manor Convalescent Home</u>   |  |                                     |  | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  |  |  |
|  |  |                                     |  | d. STREET ADDRESS <u>1605 Virginia Ave.</u>  |  |  |  |
|  |  |                                     |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ELLEN</u> Last <u>JONES</u>  |  |                                     |  | 4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1958</u>  |  |  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u>       |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>7/8/1880</u>   |  |
|  |  |                                     |  | 9. AGE (In years last birthday) <u>78</u> yrs.   |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>           |  |
|  |  |                                     |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                               |  |
| 13. FATHER'S NAME <u>James R Earnshaw</u>  |  |                                     |  | 14. MOTHER'S MAIDEN NAME <u>H Louise Bell</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>None</u> |  | 17. INFORMANT <u>George D Jones</u>  |  | Address <u>Hagerstown Maryland</u>                                       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>443x Arteriosclerotic Heart Disease</u><br>DUE TO <u>Coronary Arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260x Hypertension C V Disease</u><br>(b) <u>Unkown</u><br>(c) <u>Unkown</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0 Disruptive Melitum @ fracture femur 10/19/57</u> |  |                                     |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
|  |  |                                     |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that I attended the deceased from <u>April 4</u> , 19 <u>55</u> , to <u>July 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 23</u> , 19 <u>58</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.   |  |                                     |  |  |  |  |  |
| ACTUAL SIGNATURE <u>L L Packer Jr</u> M.D.   |  |                                     |  | ADDRESS (Street, city or town, state) <u>145 W. Washington St.</u>   |  | DATE SIGNED <u>7/25/58</u>   |  |
| PHYSICIAN'S NAME (Type) <u>L.L. PACKER, JR., M.D.</u>  |  |                                     |  | <u>Hagerstown, Maryland</u>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>7/26/58</u>    |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Funeral Home</u> ADDRESS <u>Hagerstown Maryland</u>  |  |                                     |  | 24a. REC'D BY REGISTRAR <u>24 REGISTRAR'S SIGNATURE</u> DATE <u>JUL 29 '58</u>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## 8482 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown R #2</b><br>c. LENGTH OF STAY IN 1b<br><b>29 Yrs</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Western Pike</b>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown R #2</b><br>d. STREET ADDRESS<br><b>Western b Pike</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>WALTER MORTEMORE KENDALL</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>July 29 1958</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>August 18 1877</b> |
| 9. AGE (In years last birthday) yrs.<br><b>80</b>   |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>80</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstow Wash. Co Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>George Bishop Kendall</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Boltz</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |   |
| 17. INFORMANT<br><b>Zelda S. Kendall</b>  |                                  | Address<br><b>Hagerstown Md. R #2</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Cerebral Thrombosis</b> DUE TO <b>Heart Disease</b><br>(c) <b>5 yrs</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b> |                                  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>6-1-58</b> , 19 <b>58</b> , to <b>7-29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-12-58</b> , and that death occurred at <b>7</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, State)<br>DATE SIGNED <b>7-29-58</b>   |                                  |   |   |
| ACTUAL SIGNATURE <b>J. E. W. Dittus</b>   |                                  | PHYSICIAN'S NAME (Type) <b>J. E. W. Dittus</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>8/1/58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>st Pauls Cemetary near Clear Spring Wash. Co Md</b>  |                                  | 22d. LOCATION (City, town, or county) (State)   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>  |                                  | ADDRESS<br><b>Hagerstown Md.</b>  |   |
| 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 4 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Edick</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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 2. Particular  
 3. Conclusion

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7-56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8483

## CERTIFICATE OF DEATH

08453

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>                         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smithsburg</b>   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Smithsburg</b>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>54 S. Main St.</b>   |                                  | e. STREET ADDRESS<br><b>54 S. Main St.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elmer</b> Middle <b>Charles</b> Last <b>Kindle</b>  |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>31</b> Year <b>1958</b>  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 25, 1885</b> |
| 9. AGE (In years last birthday)<br><b>73</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>labor foremen</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>railroad</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Smithsburg, Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>David Kindle</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Susann R. Bowman</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>705-10-4646</b>   |   |
| 17. INFORMANT<br><b>Martha S. Kindle, Smithsburg, Md.</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion / acute</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arteriosclerotic Heart</b><br>DUE TO<br>(c) <b>Generalized Arterio Sclerosis</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mts</b><br><b>10 yrs</b><br><b>18 yrs</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>July 25, 1958</b> to <b>July 31, 1958</b> , that I last saw the deceased alive on <b>July 31, 1958</b> , and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Smithsburg, Md.</b> DATE SIGNED <b>7/31/58</b>  |                                  |   |   |
| ACTUAL SIGNATURE <b>G.A. Koller</b> M.D.  |                                  | DATE SIGNED <b>7/31/58</b>  |   |
| PHYSICIAN'S NAME (Type) <b>G.A. Koller</b>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>Aug. 2, 58</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Smithsburg, cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg, Md.</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Smithsburg, Md.</b>  |                                  | 24a. REC'D BY REGISTRAR<br><b>DATE AUG 4 '58</b>  |   |
| 24b. REGISTRAR'S SIGNATURE<br><b>W. Search</b>  |                                  |   |   |

CERTIFICATE OF DEATH

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED<br>JAMES EARL RAY     |  | 2. SEX<br>Male                          |  | 3. AGE<br>35                              |  | 4. DATE OF BIRTH<br>Jan 5, 1928             |  | 5. PLACE OF BIRTH<br>Jackson, Mississippi |  |
| 6. OCCUPATION<br>Attorney                 |  | 7. MARITAL STATUS<br>Single             |  | 8. COLOR<br>White                         |  | 9. RELIGION<br>Methodist                    |  | 10. EDUCATION<br>High School              |  |
| 11. CAUSE OF DEATH<br>Heart Disease       |  | 12. MANNER OF DEATH<br>Natural          |  | 13. PLACE OF DEATH<br>St. Louis, Missouri |  | 14. DATE OF DEATH<br>April 4, 1968          |  | 15. TIME OF DEATH<br>2:01 PM              |  |
| 16. SIGNATURE OF PHYSICIAN<br>[Signature] |  | 17. SIGNATURE OF WITNESS<br>[Signature] |  | 18. SIGNATURE OF DECEASED<br>[Signature]  |  | 19. SIGNATURE OF NEXT OF KIN<br>[Signature] |  | 20. SIGNATURE OF REGISTRAR<br>[Signature] |  |
| 21. COUNTY<br>St. Louis                   |  | 22. CITY<br>St. Louis                   |  | 23. STATE<br>Missouri                     |  | 24. ZIP CODE<br>63101                       |  | 25. OTHER<br>None                         |  |

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF VITAL RECORDS OF THE STATE OF MISSOURI.

8443

CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                                  |  |   |  |   |   |  |
|---|----------------------------------|--|---|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>  |                                  |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> ✓                                    |   |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>   |                                  |  |   | d. STREET ADDRESS <u>Route #2</u>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lura</u> Middle <u>Edith</u> Last <u>Kerlin</u>   |                                  |  |   | 4. DATE OF DEATH<br>Month <u>July</u> Day <u>8</u> Year <u>1958</u>  |   |   |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>March 26, 1915</u> | 9. AGE (In years last birthday)<br><u>43</u> yrs.  | IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____ | IF UNDER 24 HRS.<br>Months _____ Days _____ Hours _____ Min. _____                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Laborer</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Fairchild Aircraft</u>   |   | 11. BIRTHPLACE (State or foreign country)<br><u>Fulton Co. Penna</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Gilson Kerlin</u>   |                                  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Lavada Kelso</u>  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>203-10-436</u>   |   | 17. INFORMANT<br><u>Mr. Kenneth Kerlin, Greencastle Pa</u>   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of the chest</u><br>DUE TO <u>170X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma of the breast</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> |                                  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>4 years</u>                 |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. _____ p. m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) _____ (County) _____ (State) _____                                |  |
| 21. I certify that I attended the deceased from <u>May 6</u> , 19 <u>58</u> , to <u>July 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 8</u> , 19 <u>58</u> , and that death occurred at <u>7 A</u> . M, from the causes and on the date stated above.   |                                  |  |   |  |   |   |  |
| ACTUAL SIGNATURE <u>John C. Stauffer</u>  |                                  |  |   | ADDRESS (Street, city or town, state) <u>145 South Prospect Street</u>   |   |   |  |
| PHYSICIAN'S NAME (Type) <u>John C. Stauffer, M.D.</u>   |                                  |  |   | DATE SIGNED _____  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>7/10/1958</u>  |   | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Clear Ridge Cemetery</u>  |   | 22d. LOCATION (City, town, or county) (State)<br><u>Clear Ridge, Fulton Co. Penna</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Harold M. Zimmerman</u>  |                                  |  |   | ADDRESS<br><u>Greencastle Pa</u>   |   | 24. REC'D BY REGISTRAR<br>DATE <u>JUL 11 '58</u>                                      |  |
|   |                                  |  |   | 25. REGISTRAR'S SIGNATURE<br><u>W. H. Search</u>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08455

|   |   |   |  |   |   |  |   |
|---|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |   |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   |   |  | c. LENGTH OF STAY IN 1b<br><b>52 years</b>  |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>384 Key Circle</b>   |   |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Anna</b> Middle <b>Katherine</b> Last <b>Kuhn</b>   |   |   |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>10</b> Year <b>1958</b>  |   |  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 18, 1883</b>  | 9. AGE (In years last birthday)<br><b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>19</b> Hours <b>58</b>  | IF UNDER 24 HRS.<br>Hours <b>58</b> Min.                               |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House Wife</b>  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Clumberland Md.</b> |  | 12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>John Riehl</b>  |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Martha Rump</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>--</b>   |   | 16. SOCIAL SECURITY NO.<br><b>--</b>  |  | 17. INFORMANT<br><b>Mrs. William Hovermill</b> Address <b>Hagerstown Md.</b>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Months.</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None.</b>   |   |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |  |   |
| 20c. TIME OF INJURY<br>Hour a. m. _____ p. m. _____<br>Month _____ Day _____ Year <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |   | 20f. (City or town) _____ (County) _____ (State) _____              |  |   |
| 21. I certify that I attended the deceased from <b>June 25, 1958</b> , to <b>July 10, 1958</b> , that I last saw the deceased alive on <b>July 10, 1958</b> , and that death occurred at <b>5:00 P.M.</b> , from the causes and on the date stated above.   |   |   |  |   |   |  |   |
| ACTUAL SIGNATURE<br><b>R.A. Bell</b>  |   | ADDRESS (Street, city or town, state)<br><b>119 North Potomac Street Hagerstown Maryland.</b>   |  |   |   |  |   |
| PHYSICIAN'S NAME (Type)<br><b>R.A. Bell, M.D.</b>   |   | DATE SIGNED<br><b>7-11-58</b>   |  |   |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |   | 22b. DATE THEREOF<br><b>7-13-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home</b>   |   |   |  | ADDRESS<br><b>Hagerstown Md.</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 15 1958</b>                     |   |
|   |   |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Overhach</b>   |   |  |   |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8484 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 11, 12 Film 232 7-30-58 et

08456

Reg. Dist. No.

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b><br>c. LENGTH OF STAY IN lb <b>59 years</b><br>d. NAME OF FURNAL OR INSTITUTION (If not in hospital, give street address) <b>Route 1</b>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b><br>d. STREET ADDRESS <b>Route 1</b><br>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>John Henry Kuhn</b><br>First Middle Last<br>4. DATE OF DEATH <b>July 13 19 58</b><br>Month Day Year  |  | 5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <b>Oct. 5, 1898</b> 9. AGE (In years last birthday) <b>60</b> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>cannery</b><br>11. BIRTHPLACE (State or foreign country) <b>Smithsburg, Maryland</b><br>12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>  |  | 13. FATHER'S NAME <b>Henry Kuhn</b> 14. MOTHER'S MAIDEN NAME <b>Cleta Myers</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Mrs. Mary K. Smith, Hag. Rd 1, Md.</b> Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1 Acute Coronary Occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b)<br>(c), stating the underlying cause last. DUE TO (c)  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>None 19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b> 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b><br>EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>7-21-58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>   |  | 22b. DATE THEREOF <b>7-16-58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Stouffer's Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Greensburg, Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home, Hagerstown, Md.</b> ADDRESS   |  | 24a. REC'D BY REGISTRAR <b>DATE JUL 23 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>   |  |

MARYLAND STATE DEPARTMENT OF HEALTH—BIRTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Residence

Age

Sex

House

Street

John

Henry

John

White

Married

Male

Occupation

Unemployed

Family

Five

Signature of Medical Examiner

Signature of Informant

Signature of Registrar

Signature of Informant

Signature of Medical Examiner

Signature of Registrar

Signature of Informant

Signature of Medical Examiner

Signature of Registrar

Signature of Informant

Signature of Medical Examiner

Signature of Registrar

Signature of Informant



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8445

## CERTIFICATE OF DEATH

08457

Reg. Dist. No.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>c. LENGTH OF STAY IN 1b<br><b>1 week</b><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Washington</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b><br>d. STREET ADDRESS<br><b>1</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Walter</b> Middle <b>Lee</b> Last <b>Lambert</b>   |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>26</b> Year <b>19 58</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>October 22, 1888</b><br>9. AGE (In years lost birthday) <b>69</b> yrs.     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Insurance Agent</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Life Insurance</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |
| 13. FATHER'S NAME<br><b>Lewis Lambert</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Leah Golly</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>Mrs. E. F. Lambert, Hagerstown, Md.</b>   |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC DILATATION, ACUTE</b><br>DUE TO <b>HYPERTENSIVE HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UNKNOWN</b><br>(c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HOUR</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>BRONCHIECTASIS, SEVERE</b>  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <b>11/06/48</b> , 19____, to <b>07/26/58</b> , 19____, that I last saw the deceased alive on <b>07/26/58</b> , 19____, and that death occurred at <b>1:45 P</b> M, from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) DATE SIGNED                      |   |  |   |
| ACTUAL SIGNATURE <b>Archie Robert Cohen</b> M.D.  |   | DATE SIGNED <b>07/28/58</b>  |   |
| PHYSICIAN'S NAME (Type) <b>ARCHIE ROBERT COHEN, M.D. CLEAR SPRING, MD.</b>  |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>7/29/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Lutheran Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Harney, Maryland</b>                          |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>C.O. Fuss &amp; Son</b>  |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 30 '58</b>  |   |
| ADDRESS<br><b>Taneytown, Maryland</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. E. Couch</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• *Journal of the American Medical Association*, 1997; 277: 1001-1005

STUDY, AGITATION, CALMNESS

HYPERTEXTIVE: 354RT 01 SEP 28

253V32, 212AT03190K098

83150

848011

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.9.3

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8446 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08458

Reg. Dist. No.

|   |                                    |   |                                       |
|---|------------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown, Maryland</b>   |                                    | c. LENGTH OF STAY IN 1b<br><b>55yrs</b>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>DOA Washington County Hospital</b>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Daniel</b> Middle <b>(no)</b> Last <b>Lee</b>   |                                    | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>19 58</b>  |                                       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Colored</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb 7 1898</b> |
| 9. AGE (In years last birthday)<br><b>60</b> yrs.   |                                    | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Janitor</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private family</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>Berryville Va.</b>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                       |
| 13. FATHER'S NAME<br><b>John Lee</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Rene Carter</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>   |                                    | 16. SOCIAL SECURITY NO.<br><b>214-28-5523</b>   |                                       |
| 17. INFORMANT<br><b>Marie Lee</b>   |                                    | Address<br><b>323 N. Jonathan Street</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic myocardial heart disease</b><br><b>420.1</b> DUE TO <b>Acute coronary occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                    |   |                                       |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH: <b>none</b>  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |                                       |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour <b>none</b> a. m. <b>19</b> p. m.   |                                    | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |                                    | 20f. (City or town) (County) (State)<br><b>- - -</b>  |                                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                                    |   |                                       |
| ACTUAL SIGNATURE<br><b>S. Robert Wells</b>  |                                    | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                                       |
| EXAMINER'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>  |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                       |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                    | DATE SIGNED<br><b>7-7-58</b>  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                    | 22b. DATE THEREOF<br><b>7-8-1958</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |                                    | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John R Watson Jr. Hagerstown Md</b>  |                                    | 24a. REC'D BY REGISTRAR<br><b>DATE JUL 9 '58</b>  |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><b>Q. L. Beach</b>  |                                    |   |                                       |

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|                            |  |                            |  |
|----------------------------|--|----------------------------|--|
| NAME OF DECEASED           |  | RESIDENCE                  |  |
| JAMES H. HARRIS            |  | Baltimore, Maryland        |  |
| AGE                        |  | SEX                        |  |
| 65                         |  | Male                       |  |
| DATE OF DEATH              |  | PLACE OF DEATH             |  |
| Jan 1, 1900                |  | Home                       |  |
| CAUSE OF DEATH             |  | MANNER OF DEATH            |  |
| Heart Failure              |  | Natural                    |  |
| DISEASE                    |  | SYMPTOMS                   |  |
| Hypertension               |  | Hypertension               |  |
| Coronary Artery Disease    |  | Coronary Artery Disease    |  |
| Myocardial Infarction      |  | Myocardial Infarction      |  |
| Atherosclerosis            |  | Atherosclerosis            |  |
| Hypertensive Heart Disease |  | Hypertensive Heart Disease |  |
| Ischemic Heart Disease     |  | Ischemic Heart Disease     |  |
| Congestive Heart Failure   |  | Congestive Heart Failure   |  |
| Chronic Heart Failure      |  | Chronic Heart Failure      |  |
| Acute Heart Failure        |  | Acute Heart Failure        |  |
| Sudden Death               |  | Sudden Death               |  |
| Trauma                     |  | Trauma                     |  |
| Poisoning                  |  | Poisoning                  |  |
| Infection                  |  | Infection                  |  |
| Injury                     |  | Injury                     |  |
| Suicide                    |  | Suicide                    |  |
| Homicide                   |  | Homicide                   |  |
| Undetermined               |  | Undetermined               |  |
| Other                      |  | Other                      |  |

John R. Watson, Jr. M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the funeral home. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8447

## CERTIFICATE OF DEATH

Reg. Dist. No.

08459

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Life</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>2114 1/2 Virginia Ave</b>  |                                  | d. STREET ADDRESS<br><b>2114 1/2 Virginia Ave</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Sara Clyften Le Fevre</b>   |                                  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>24</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 5, 1882</b>                              |
| 9. AGE (In years last birthday)<br><b>75</b> yrs.   |                                  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machine Operator</b>                                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dress</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Hagerstown Md.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Md.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Jacob Le Fevre</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Dora Feigley</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]<br><b>no</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>214-09-8281</b>  |  |
| 17. INFORMANT<br><b>Frank L. Royston</b>  |                                  | Address<br><b>Hagerstown Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of bowel</b><br><b>153.8</b> DUE TO <b>Acute Intestinal Obstruction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mos ?</b><br><b>3 days</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>None</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>None</b> <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>   |                                  | 20f. (City or town) (County) (State)<br><b>- - -</b>   |  |
| 21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> , to <b>July</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 24</b> , 19 <b>54</b> , and that death occurred at <b>1:05 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b> DATE SIGNED <b>7-25-58</b>  |                                  |  |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b>   |                                  | M.D. <b>115 N. Potomac Street</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>   |                                  | <b>Hagerstown, Maryland</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 22b. DATE THEREOF<br><b>7-26-58</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home</b>   |                                  | ADDRESS<br><b>Hagerstown Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br><b>JUL 29 '58</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |





8448

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                               |  |                                       |   |  |  |                  |
|---|-------------------------------|--|---------------------------------------|---|--|--|------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> MARYLAND   |                               |  |                                       | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> |  |  |                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>  |                               |  |                                       | c. LENGTH OF STAY IN 1b <u>77 DAYS</u>  |  |  |                  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>   |                               |  |                                       | d. STREET ADDRESS <u>933 SALEM</u>  |  |  |                  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES RAYMOND MCKANE</u>   |                               |  |                                       | 4. DATE OF DEATH Month Day Year <u>JULY 15 1958</u>   |  |  |                  |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>APRIL 2, 1870</u> | 9. AGE (In years last birthday) <u>88</u> yrs.  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RAILROAD CONDUCTOR</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>RAILWAY</u>   |                                       | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                  |
| 13. FATHER'S NAME <u>GEORGE MCKANE</u>  |                               |  |                                       | 14. MOTHER'S MAIDEN NAME <u>MARY BOWERS.</u>  |  |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>  |                               | 16. SOCIAL SECURITY NO. <u>705-10-5376</u>   |                                       | 17. INFORMANT <u>Mrs. Sara K. McKane, Hagerstown, Md.</u>   |  | Address <u>933 Salem Ave</u>   |                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA &amp; CONGESTION</u><br>204.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>260X</u><br>(b) <u>ACUTE HEPATIC NECROSIS</u><br>(c) <u>GRANULOCYTIC LEUKEMIA</u> |                               |  |                                       |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 WEEKS.</u><br><u>UNKNOWN</u><br><u>8 MONTHS</u>       |                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS. RENAL CORTICAL ABSCESSSES</u>   |                               |  |                                       |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                               |  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |                  |
| 21. I certify that I attended the deceased from <u>APRIL 29, 1958</u> to <u>JULY 15, 1958</u> , that I last saw the deceased alive on <u>JULY 15, 1958</u> , and that death occurred at <u>1:35 A.M.</u> from the causes and on the date stated above.  |                               |  |                                       |   |  |  |                  |
| ACTUAL SIGNATURE <u>George Bercu</u>  |                               |  |                                       | ADDRESS (Street, city or town, state) DATE SIGNED <u>1500 PENNSYLVANIA AVE, 7/15/58</u>   |  |  |                  |
| PHYSICIAN'S NAME (Type) <u>DR. GEORGE BERCU.</u>  |                               |  |                                       | <u>HAGERSTOWN, MD.</u>  |  |  |                  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                               | 22b. DATE THEREOF <u>7/17/58</u>   |                                       | 22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery Hagerstown,</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>MD.</u>                                       |                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>SUPER-ROBERT FUM, HOME</u>  |                               |  |                                       | ADDRESS <u>305 N Potomac St</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE JUL 17 '58</u>   |                  |
| <u>Ray J. Dawson</u>  |                               |  |                                       | <u>HAGERSTOWN MD</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Robert Fum</u>   |                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 302

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Washington</b>   |  | MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>Maryland</b>  |  | b. COUNTY<br><b>Washington</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Wash County Hospital</b>   |  |   |  | d. STREET ADDRESS<br><b>2432 Penna Ave</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>MARK</b>   |  | First<br><b>KERMIT</b>  |  | Middle<br><b>MILLER</b>   |  | Last  |  |
| 5. SEX<br><b>Male</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>August 16 1911</b>   |  |
|   |  |   |  | 9. AGE (In years last birthday)<br><b>46</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>County Agricultural Agent Wash. Co</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Agent Wash. Co</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Co Penna Herndon Northumberland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Lain Miller</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Katie Brower</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>378-36-3119</b>   |  | 17. INFORMANT<br><b>Mrs Adele Miller 2432 Penna Ave</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Coronary Thrombosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (c) _____                       |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hour</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <b>July 12, 1958</b> , to <b>July 12, 1958</b> , that I last saw the deceased alive on <b>July 12, 1958</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above<br>ADDRESS (Street, city or town, state) <b>214 N. Potomac st Hagerstown, Md.</b> DATE SIGNED <b>7/14/58</b> |  |   |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>Lloyd A. Hoffman</b>   |  | PHYSICIAN'S NAME (Type)<br><b>Lloyd A. Hoffman Hagerstown, Md.</b>  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>7/16/58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Grand Army Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Summit Hill Carbon Co Penna</b>               |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>  |  |   |  | ADDRESS<br><b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 16 '58</b>   |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





8485

## CERTIFICATE OF DEATH

08462

Reg. Dist. No.

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <b>WASHINGTON</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> COUNTY <b>WASHINGTON</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BEAVER CREEK RURAL</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>12 YEARS</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>HAGERSTOWN MD. R.1</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MELVIN</b> Middle <b>PRESTON</b> Last <b>MONNINGER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JULY</b> Day <b>6</b> Year <b>1958</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 1 1907</b>  |
| 9. AGE (In years last birthday)<br><b>51</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BROADFORDING WASH.CO.MD.U.S.A.</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>BROADFORDING WASH.CO.MD.U.S.A.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>JACOB B. MONNINGER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>DELLA MAE DRURY</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>219 20 2309</b>   |   |
| 17. INFORMANT<br><b>MRS. HELEN E. MONNINGER</b>  |                                  | Address<br><b>HAGERSTOWN MD. R.1</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas (Head)</b><br><b>157X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>with metastases abdominal</b><br>DUE TO (c) |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Feb 1957</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <b>July 5, 1958</b> to <b>July 6, 1958</b> that I last saw the deceased alive on <b>July 6, 1958</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE <b>Sidney Novenstein</b> M.D.   |                                  | ADDRESS (Street, city or town, state) <b>2 Park Ave N</b> DATE SIGNED <b>7-7-58</b>   |   |
| PHYSICIAN'S NAME (Type) <b>SIDNEY NOVENSTEIN</b>   |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 22b. DATE THEREOF<br><b>JULY 9 1958</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>BEAVER CREEK CEMETERY</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>BEAVER CREEK WASH.CO.MD.</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. Bass Boonshu Md</b>   |                                  | 24a. REC'D BY REGISTRAR<br><b>JUL 11 '58</b>  |   |
| ADDRESS  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Search</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8486

## CERTIFICATE OF DEATH

08463

Reg. Dist. No.

|   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>WASHINGTON</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BOONSBORO</b> |  | c. LENGTH OF STAY IN 1b<br><b>24 YEARS</b>   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>WASHINGTON</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BOONSBORO</b>   |  | d. STREET ADDRESS<br><b>113 LAKIN AVENUE</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                      |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>CLEMMIE IRENE MULLENDORE</b>                       |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JULY 24 1958</b>  |  | 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>OCTOBER 17 1876</b>   |  | 9. AGE (In years last birthday)<br><b>81</b> yrs.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>HOUSE KEEPER</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>OWN HOME</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>ROHRERSVILLE WASH.CO. MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>DANIEL EASTON</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY ROHRER</b>   |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b> |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>MRS. WINOLA CHARLES</b>  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>332X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerosis</b> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>July 12-58</b> |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town)  |  | (County)   |  | (State)  |  | 21. I certify that I attended the deceased from <b>July 12</b> , 19 <b>58</b> , to <b>July 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 24</b> , 19 <b>58</b> , and that death occurred at <b>9:45 A.M.</b> , from the causes and on the date stated above. |  | ADDRESS (Street, city or town, state)<br><b>2400 S. Main St. Md.</b>                         |  | DATE SIGNED<br><b>7-25-58</b>  |  |  |  |
| ACTUAL SIGNATURE<br><b>Sidney Novenstein</b>  |  | M.D.<br><b>SIDNEY NOVENSTEIN</b>   |  | PHYSICIAN'S NAME (Type)<br><b>SIDNEY NOVENSTEIN</b>  |  | 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>JULY 26 1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>BOONSBORO CEMETERY</b>                              |  | 22d. LOCATION (City, town, or county) (State)<br><b>BOONSBORO WASH.CO.MD.</b>  |  |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John H. East</b>   |  | ADDRESS<br><b>Boonsboro Md.</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE<br><b>JUL 29 1958</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Arthur</b>  |  |  |  |  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

|  |  |
|--|--|
| <p>1. Name of Deceased: <u>JOHN DOE</u></p>              |  |
| <p>2. Date of Death: <u>1945-12-25</u></p>               |  |
| <p>3. Place of Death: <u>Home</u></p>                    |  |
| <p>4. Cause of Death: <u>Heart Disease</u></p>           |  |
| <p>5. Age at Death: <u>75</u></p>                        |  |
| <p>6. Sex: <u>Male</u></p>                               |  |
| <p>7. Race: <u>White</u></p>                             |  |
| <p>8. Marital Status: <u>Married</u></p>                 |  |
| <p>9. Occupation: <u>Teacher</u></p>                     |  |
| <p>10. Signature of Physician: <u>[Signature]</u></p>    |  |
| <p>11. Signature of Registrar: <u>[Signature]</u></p>    |  |
| <p>12. Date of Registration: <u>1946-01-05</u></p>       |  |
| <p>13. Place of Registration: <u>City Hall</u></p>       |  |
| <p>14. Notes: <u>Deceased was found dead in bed.</u></p> |  |

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 13.14 111-231 7-11-58 et

8450

## CERTIFICATE OF DEATH

Reg. Dist. No.

08464

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>WASHINGTON</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u><br>c. LENGTH OF STAY IN TB <u>26 DAYS</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WESTERN MARYLAND STATE HOSPITAL</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>BALTIMORE</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u><br>d. STREET ADDRESS <u>678 W. BALTIMORE ST.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>BEULAH</u> <span style="float: right;">First Middle Last</span><br><b>4. DATE OF DEATH</b> <u>JULY 9 1958</u> <span style="float: right;">Month Day Year</span>  |  |  |  | <b>5. SEX</b> <u>FEMALE</u><br><b>6. COLOR OR RACE</b> <u>WHITE</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>NOVEMBER 29, 1893</u><br><b>9. AGE</b> (In years last birthday) <u>64</u> yrs.   |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u><br><b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u><br><b>11. BIRTHPLACE</b> (State or foreign country) <u>WEST VIRGINIA</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>  |  |  |  | <b>13. FATHER'S NAME</b> <u>Wm. Hull</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>   |  |   |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/><br>(If yes, give war or dates of service)   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>17. INFORMANT</b> <span style="float: right;">Address</span>  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>BILATERAL LOBULAR PNEUMONIA</u><br><u>181.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <u>CARCINOMA OF URINARY BLADDER</u><br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PYELOHYDRONEPHROSIS (BILATERAL). PULMONARY EDEMA</u> |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 DAYS</u><br><u>3 YEARS</u>                                 |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><u>490x</u>  |  |  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town)</b> (County) (State)   |  |
| <b>21. I certify that I attended the deceased from</b> <u>JUNE 13, 1958</u> <b>to</b> <u>JULY 9, 1958</u> , <b>that I last saw the deceased alive on</b> <u>JULY 9, 1958</u> , <b>and that death occurred at</b> <u>3:25 PM</u> , <b>from the causes and on the date stated above.</b>   |  |  |  |  |  |   |  |
| <b>ACTUAL SIGNATURE</b> <u>George Beren</u><br><b>PHYSICIAN'S NAME (Type)</b> <u>DR. G. BERCU</u>  |  |  |  | <b>ADDRESS</b> (Street, city or town, state) <u>1500 PENNSYLVANIA AVE, BALTIMORE, MD.</u><br><b>DATE SIGNED</b> <u>7/9/58</u>  |  |   |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>22b. DATE THEREOF</b> <u>7-12-58</u>  |  | <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Louden Park</u>   |  | <b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>                     |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u><br><b>ADDRESS</b> <u>1217 St Paul St</u>  |  |  |  | <b>24a. REC'D BY REGISTRAR</b> <u>[Signature]</u><br><b>DATE</b> <u>JUL 11 '58</u>   |  | <b>24b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08465

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Indiana</b> b. COUNTY <b>Putnam</b>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   | c. LENGTH OF STAY IN 1b<br><b>3 weeks</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Greencastle</b> 52x-3   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Washington County Hospital</b>   |  | d. STREET ADDRESS<br><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Omer</b>  | First <b>Omer</b> Middle <b>Nelson</b> Last <b>Nelson</b>  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>25</b> Year <b>19 58</b>  |   |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>1878</b>   |
| 9. AGE (in years last birthday)<br><b>80</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>80</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   | IF UNDER 24 HRS.<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unknown</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Putnam Co., Indiana</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>Putnam Co., Indiana</b>   |   |
| 13. FATHER'S NAME<br><b>unknown</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Eva J. Cole</b>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>Spanish American</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Spanish American</b>   |   |
| 17. INFORMANT<br><b>Chas. H. Rector, Greencastle, Ind.</b>  |  | Address<br><b>Chas. H. Rector, Greencastle, Ind.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary embolus</b><br><b>416x</b> DUE TO <b>Compressed fracture 2nd lumbar vertebrae</b><br>Conditions, if any, which gave rise to immediate cause (b) <b>Osteoporosis of spinal vertebrae</b><br>(c) <b>Rheumatic valvular heart disease</b><br>(d) <b>Arteriosclerotic myocardial heart disease</b><br>(e) <b>Sub-Acute pancreatitis</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 days</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>904.5</b> <b>None</b>   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Passenger in bus that was traveling over rough road and he received sudden pain in his back</b> |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>4:30 p.m. July 5 19 58</b>  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Highway</b>   | 20f. (City or town) (County) (State)<br><b>Rural Mercersburg, Frank., Pa</b>                      |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>         |  |  |   |
| ACTUAL SIGNATURE<br><b>S. Robert Wells</b>  |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>7-26-58</b>  |   |
| EXAMINER'S NAME (Type)<br><b>S. Robert Wells, M.D.</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 22b. DATE THEREOF<br><b>7-29-58</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Boone-Hutcheson Ceme.</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Putnam Co., Indiana</b>                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Hagerstown, Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JUL 29 '58</b><br>DATE   |   |

STATE OF  
MISSISSIPPI

County of Washington

Know all men by these presents, that I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court of the County of Washington, Mississippi.

Witness my hand and seal of office this 1st day of January, 1901.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

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Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BUREAU OF  
PUBLIC MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County of Washington

Know all men by these presents, that I, the undersigned, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of the Court of the County of Washington, Mississippi.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

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Notary Public for the State of Mississippi

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Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

My commission expires the 1st day of January, 1902.

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the State of Mississippi

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08468

Reg. Dist. No.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY Washington MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Washington                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown   | c. LENGTH OF STAY IN 1b 70 yrs  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown,  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital   |   | d. STREET ADDRESS 1 245 S. Potomac Street  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Bessie Camille Newcomer   |   | 4. DATE OF DEATH July 13 19 58   |  |
| 5. SEX Female   | 6. COLOR OR RACE White  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan/ 6, 1870  |
| 9. AGE (In years last birthday) 88 yrs.   |   | IF UNDER 1 YEAR Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |   | 10b. KIND OF BUSINESS OR INDUSTRY Home   | 11. BIRTHPLACE (State or foreign country) Maryland   |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |   |  |  |
| 13. FATHER'S NAME Ezra Newcomer   |   | 14. MOTHER'S MAIDEN NAME Ann Clara Hammond   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No   |   | 16. SOCIAL SECURITY NO. None   | 17. INFORMANT Address Mr. Harry Newcomer - Hagerstown, Md                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 493.1 Advanced generalized arteriosclerosis<br>DUE TO Arteriosclerotic myocardial heart disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute ventricular fibrillation<br>DUE TO Closed fracture neck of lt femur (c)                                    |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Duodenal ulcer  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour 9 58 June 25 19 58  | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home   | 20f. (City or town) Hagerstown (County) Wash. (State) Md                                       |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE S. Robert Wells  |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) S. Robert Wells, M.D.  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial  |   | 22b. DATE THEREOF 7-15-58  | 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery  |
| 22d. LOCATION (City, town, or county) Hagerstown  |   | (State) Wash Md  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant   |   | ADDRESS Hagerstown   |  |
| 24a. REC'D BY REGISTRAR   |   | 24b. REGISTRAR'S SIGNATURE   |  |
| DATE JUL 16 '58   |   |  |  |





8453

## CERTIFICATE OF DEATH

08467

Reg. Dist. No. 302

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Washington</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Virginia</b> b. COUNTY <b>Henrico</b>                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |   |  | c. LENGTH OF STAY IN TB<br><b>3 months</b>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><b>Washington County Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>Dora Whitlock Osborne</b>  |  |   |  | 4. DATE OF DEATH Month Day Year<br><b>July 12 19 58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>March 29, 1878</b>                                  |  |
| 9. AGE (In years last birthday)<br><b>80 yrs.</b>  |  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>3 13</b>  |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Floyd County, Va.</b>      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>Samuel Henry Whitlock</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Fisher</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |  | 17. INFORMANT<br><b>C. A. Osborne, Templeman, Va.</b>   |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis due to</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio-sclerotic Heart D.</b><br>DUE TO<br>(c) <b>Generalized Arteriosclerosis</b> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs</b>   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>260X Diabetes Mellitus</b>   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I attended the deceased from <b>July 1, 19 58</b> , to <b>July 13, 19 58</b> , that I last saw the deceased alive on <b>July 13, 19 58</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above.  |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>Sidney Novenstein</b>   |  |   |  | ADDRESS (Street, city or town, state)<br><b>Richmond, Virginia</b>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><b>SIDNEY NOVENSTEIN</b>  |  |   |  | DATE SIGNED<br><b>7-13-58</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>7-14-1958</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Forest Lawn Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Richmond, Virginia</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Woody Fun. Home</b>   |  |   |  | ADDRESS<br><b>305 N. Potomac St. Va</b>   |  | 24a. REC'D BY REGISTRAR<br><b>Jul 15 '58</b>                               |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Bohannon</b>   |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 2-543. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18   |                                  |   |   |   |   |   |   |   |  | 08468  |
|---|----------------------------------|---|---|---|---|---|---|---|--|--|
| 8487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                                  |   |   |   |   |   |   |   |  | Reg. Dist. No.   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>MARYLAND  |                                  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |   |   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Weverton</b>  |                                  |   | c. LENGTH OF STAY IN 1b <b>Life</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Weverton</b>  |   |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |                                  |   |   |   | d. STREET ADDRESS   |   |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Williama</b> Middle <b>Henry</b> Last <b>Phillips</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>4</b> Year <b>19 58</b>                                      |   |   |   |   |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>3-28-1878</b>                                  |   | 9. AGE (In years and day)<br><b>80</b> yrs. | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.                              |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Farmer</b>  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Crop</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                               |   |  |  |
| 13. FATHER'S NAME<br><b>Daniel Wesley Phillips</b>  |                                  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Huntsbury</b>  |   |   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b><br>(If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>Mr. Wesley Phillips, Knoxville, Md</b> |   |   |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arteriosclerotic myocardial heart disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>with myocardial failure grade Iv</b><br>(c) <b></b>  |                                  |   |   |   |   |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |   |   |   |   |   |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |   |   |   |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. <b>None</b> p. m. <b>19</b>   |                                  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |   |   |   |   |   |  |  |
| ACTUAL SIGNATURE <b>S. Robert Wells</b> M.D.  |                                  |   |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |   | DATE SIGNED <b>7-4-58</b>                                   |  |  |
| EXAMINER'S NAME (Type) <b>S. Robert Wells</b>   |                                  |   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                                  | 22b. DATE THEREOF <b>7-6-1958</b>   |   | 22c. NAME OF CEMETERY OR CREMATORY <b>Penticostal</b>                 |   |   | 22d. LOCATION (City, town, or county) (State)<br><b>Garroetts Mills Md.</b> |   |  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Lee Farto</b> ADDRESS <b>Brunswick, Maryland</b>  |                                  |   |   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 9 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>Qu. Leach</b>                              |   |  |  |

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8454

## CERTIFICATE OF DEATH

08469

Reg. Dist. No. 302

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>  |                               | c. LENGTH OF STAY IN 1b <b>35 Yrs</b>  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1199 The Terrace</b>  |                               | d. STREET ADDRESS <b>1199 The Terrace</b>  |   |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>EDITH FRAZER PORTER</b>  |                               | 4. DATE OF DEATH Month Day Year <b>July 23 1958 19</b>   |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec 20 1879</b>                           |
| 9. AGE (In years last birthday) <b>78</b> yrs.  |                               | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>   |                               | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>John Frazer</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>Anna Doty</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                               | 16. SOCIAL SECURITY NO. <b>None</b>  |   |
| 17. INFORMANT Address <b>Mrs Louise Moore Cherry Valley N.Y.</b>  |                               |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b><br>DUE TO<br>(c) _____                                   |                               |  | INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b><br><b>Yrs.</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <b>Jan 31, 1958</b> to <b>July 23, 1958</b> , that I last saw the deceased alive on <b>July 25, 1958</b> , and that death occurred at <b>6:58 PM</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>214 N. Potomac St. Hagerstown, Md</b> DATE SIGNED <b>7/24/58</b> |                               |  |   |
| ACTUAL SIGNATURE <b>Lloyd A. Hoffmann</b>   |                               |  |   |
| PHYSICIAN'S NAME (Type) <b>Lloyd A. Hoffmann</b>  |                               |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |                               | 22b. DATE THEREOF <b>7/26/58</b>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Glenn Farm</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Haynesboro Franklin Co Pa</b>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>   |                               | ADDRESS <b>Hagerstown Md.</b>  |   |
| 24a. REC'D BY REGISTRAR <b>JUL 29 1958</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>Carl K. ...</b>  |   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

|                        |  |                        |  |                      |  |
|------------------------|--|------------------------|--|----------------------|--|
| Name of Deceased       |  | Sex                    |  | Age                  |  |
| Date of Birth          |  | Date of Death          |  | Time of Death        |  |
| Place of Birth         |  | Place of Death         |  | Cause of Death       |  |
| Occupation             |  | Residence              |  | Manner of Death      |  |
| Signature of Physician |  | Signature of Registrar |  | Signature of Coroner |  |
| Date of Certificate    |  | Date of Registration   |  | Date of Burial       |  |

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8455

## CERTIFICATE OF DEATH

08470

Reg. Dist. No.

|  |                               |  |                                    |
|--|-------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>WASHINGTON</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>  |                               | d. STREET ADDRESS <b>1225 S. POTOMAC ST.</b>   |                                    |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |  |                                    |
| 3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ALICE</b> Last <b>REPP</b>   |                               | 4. DATE OF DEATH Month <b>JULY</b> Day <b>10</b> Year <b>19 58</b>   |                                    |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>11/29/1891</b> |
| 9. AGE (In years last birthday) <b>66</b> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BEAUTY SHOP</b>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN SHOP</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME <b>OLIVER BAKER</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>SARAH BYREM</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)  |                               | 16. SOCIAL SECURITY NO. <b>218-30-8954</b>   |                                    |
| 17. INFORMANT <b>MR. OLIVER W. MOWEN</b>   |                               | Address <b>HAGERSTOWN MD.</b>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis - General</b><br>DUE TO (c) <b>10 yrs.</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Thrombosis of Splenic Artery.</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that I attended the deceased from <b>March</b> , 19 <b>57</b> , to <b>July 10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 10</b> , 19 <b>58</b> , and that death occurred at <b>1:50 A.M.</b> , from the causes and on the date stated above.   |                               |  |                                    |
| ADDRESS (Street, city or town, state) <b>214 N. Potomac St.</b>  |                               | DATE SIGNED <b>7/11/58</b>   |                                    |
| ACTUAL SIGNATURE <b>Woyd A. Hoffman</b>  |                               | M.D. <b>Hagerstown, Md.</b>  |                                    |
| PHYSICIAN'S NAME (Type) <b>Woyd A. Hoffman</b>   |                               | <b>Hagerstown, Md.</b>   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |                               | 22b. DATE THEREOF <b>7/12/58</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment</b>  |                               | ADDRESS <b>Hagerstown, Md.</b>   |                                    |
| 24a. REC'D BY REGISTRAR <b>DATE JUL 15 '58</b>   |                               | 24b. REGISTRAR'S SIGNATURE <b>Overman</b>  |                                    |

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 15

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

08471

8488

|   |                               |  |   |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>  |                               | c. LENGTH OF STAY IN 1b <u>1 day</u>   |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thurmont</u>  |                               | d. STREET ADDRESS <u>unknown</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Appalachian Inn</u>   |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>JOSEPH MORRIS RICHARDS</u>   |                               | 4. DATE OF DEATH <u>July 30 19 58</u>  |   |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>October 7, 1905</u> |
| 9. AGE (in years last birthday) <u>52</u> yrs.  |                               | 10. IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u>   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Salesman</u>   |                               | 12. KIND OF BUSINESS OR INDUSTRY <u>Own Business</u>   |   |
| 13. FATHER'S NAME <u>Morris Richards</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Bertha Warfield</u>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates at service)   |                               | 16. SOCIAL SECURITY NO. <u>217-10-9096</u>   |   |
| 17. INFORMANT <u>Joseph M. Richard, Jr.</u>   |                               | Address <u>Baltimore, Md.</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Suffocation by hanging</u><br>974X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> |                               |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Hanged self in basement of Appalachian Inn</u>           |   |
| 20c. TIME OF INJURY Month, Day, Year <u>10 XXX July 30 19 58</u> p. m.  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Basement of Inn</u>   |                               | 20f. (City or town) <u>Rural Hagerstown, Wash Md</u> (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                       |                               |  |   |
| ACTUAL SIGNATURE <u>S. Robert Wells</u>   |                               | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>   |                               | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                               | DATE SIGNED <u>8-1-58</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>8/2/1958</u>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Blue Ridge Cemetery</u>   |                               | 22d. LOCATION (City, town, or county) <u>Thurmont, Maryland</u> (State)  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Houzer Funeral Home</u>   |                               | ADDRESS <u>Hagerstown, Md.</u>   |   |
| 24a. REC'D BY REGISTRAR <u>DATE AUG 5 '58</u>   |                               | 24b. REGISTRAR'S SIGNATURE <u>W. F. Leach</u>  |   |

WEST VIRGINIA DEPARTMENT OF HEALTH - BIRMINGHAM 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

100

7





8456

## CERTIFICATE OF DEATH

Reg. Dist. No 302

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |  |  |  | c. LENGTH OF STAY IN 1b<br><b>35 Yrs</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1222 W Washington St</b>   |  |  |  | d. STREET ADDRESS<br><b>1222 W. Washington st</b>   |  |   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>RUTH</b> Middle <b>IRENE</b> Last <b>RIDGE</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>15</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Sept 20 1896</b>   |  |
| 9. AGE (In years last birthday)<br><b>61 yrs.</b>   |  | IF UNDER 1 YEAR<br>Months <b>61</b> Days <b>15</b> Hours <b>19</b> Min.                  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife Own Home</b>                                    |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Luray Page Co Va.</b>                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 13. FATHER'S NAME<br><b>George Estep</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mollie Kline</b>                                 |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>Unable To Locate Herman E. Ridge 1222 W. Washington St</b> |  | 17. INFORMANT<br><b>Hagerstown Md.</b>  |  | Address<br><b>1222 W. Washington St</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br><b>Card iovascular Collapse.</b><br><b>731X</b><br>DUE TO<br><b>Ostitis Desfirmans - Paget's Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br><b>Unknown cause.</b><br>(c) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes.</b><br><b>Yrs.</b>  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. <b>19</b><br>p. m.   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)          |  |
| 20f. (City or town)<br><b>Hagerstown</b>  |  |  |  | 20g. (County)<br><b>Washington</b>  |  | 20h. (State)<br><b>Md.</b>  |  |
| 21. I certify that I attended the deceased from <b>4-29-58</b> , 19 <b>58</b> , to <b>7-15-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7-14-58</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.  |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>L. G. Craff</b>   |  |  |  | ADDRESS (Street, city or town, state)<br><b>119 E. Antietam St.</b>   |  |   |  |
| DATE SIGNED<br><b>7-15-58</b>   |  |  |  | M.D.<br><b>119 E. Antietam St.</b>  |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>Louis G. Craff, MD.</b>   |  |  |  | Hagerstown, Md.   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>7/17/58</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Wash. Co Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Andrew K. Coffman</b>  |  |  |  | ADDRESS<br><b>Hagerstown Md.</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JUL 17 '58</b>                                    |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>Alfred Smith</b>   |  |  |  |   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11/11/1930  
New York

CERTIFICATE OF DEATH

11-1-30

|                        |  |                        |  |
|------------------------|--|------------------------|--|
| Name of Deceased       |  | Date of Birth          |  |
| John Doe               |  | Jan 15 1880            |  |
| Sex                    |  | Age                    |  |
| Male                   |  | 50                     |  |
| Race                   |  | Color                  |  |
| White                  |  | White                  |  |
| Married                |  | Single                 |  |
| Occupation             |  | Cause of Death         |  |
| Teacher                |  | Heart Disease          |  |
| Place of Death         |  | Date of Death          |  |
| New York City          |  | Nov 1 1930             |  |
| Signature of Physician |  | Signature of Registrar |  |
| [Signature]            |  | [Signature]            |  |

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8457

## CERTIFICATE OF DEATH

08473

Reg. Dist. No.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Mercersburg, Pa.</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>   |  | d. STREET ADDRESS <u>RD2 - Mercersburg</u> 75X-3   |   |
| 3. NAME OF DECEASED (Type or print) <u>William S. Ryder</u> First Middle Last  |  | 4. DATE OF DEATH <u>July 19, 1958</u> Month Day Year   |   |
| 5. SEX <u>M</u>  | 6. COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug. 12, 1887</u>   |
| 9. AGE (In years last birthday) <u>70</u> yrs.   |  | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroader</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md R.R.</u>  |   |
| 11. BIRTHPLACE (State or foreign country) <u>Markes, Pa.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |   |
| 13. FATHER'S NAME <u>John S. Ryder</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Rebecca Kershner</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO. <u>-</u>   |   |
| 17. INFORMANT <u>Irvin Ryder - Mercersburg, Pa.</u> Address  |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u><br><u>181.0</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO<br>(c) <u>Carcinoma Bladder</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 Mo.</u><br><u>6 Mo.</u><br><u>1 1/2 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I attended the deceased from <u>7 - 17</u> , 19 <u>58</u> , to <u>7 - 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>7 - 19</u> , 19 <u>58</u> , and that death occurred <u>all 4:45 P.M.</u> from the causes and on the date stated above.   |  |  |   |
| ACTUAL SIGNATURE <u>J. G. Warden</u> M.D.  |  | ADDRESS (Street, city or town, state) <u>832 Potomac Ave.</u> DATE SIGNED  |   |
| PHYSICIAN'S NAME (Type) <u>J. G. Warden, M. D.</u>   |  | <u>832 Potomac Ave. - Hagerstown, Md.</u>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>  | 22b. DATE THEREOF <u>July 22/58</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill</u>  | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>                  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Mummich - Greencastle, Pa.</u> ADDRESS   |  | 24a. REC'D BY REGISTRAR <u>Jul 23 '58</u> DATE   | 24b. REGISTRAR'S SIGNATURE <u>Rebecca</u>   |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 01-11-2001 BY 60322 UCBAW

## 8458 CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>03 Hagerstown</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Martin Manor Nursing Home</b>  |   | d. STREET ADDRESS<br><b>1303 Vista Ave.</b>   |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>NICOLA</b> Middle <b>JOSEPH</b> Last <b>SALAMONE</b>  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>8</b> Year <b>19 58</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 2, 1882</b>                                       |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.   |   | IF UNDER 1 YEAR<br>Months <b>2</b> Days <b>6</b>  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Loader</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Stone Quarry</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Chieda, Italy</b>            |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |   |  |
| 13. FATHER'S NAME<br><b>Joseph Salamone</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Bridgeder Rosaria</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO.<br><b></b>  |  |
| 17. INFORMANT<br><b>Mrs. Margaret Gervasio</b>  |   | Address<br><b>Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>broncho pneumonia</b><br><b>332x</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>general arteriosclerosis &amp; cerebral thrombosis with senility</b><br>DUE TO (c) <b></b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>10-15 yrs</b>        |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Total Degenerative &amp; Tuberous cystic degeneration</b> (b) <b>general arteriosclerosis</b> (c) <b>prostatic hypertrophy</b>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>491X</b>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b></b>   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. <b>19</b> p. m. <b></b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b></b>   | 20f. (City or town) (County) (State)<br><b></b>                              |
| 21. I certify that I attended the deceased from <b>Aug 3, 1957</b> , to <b>July 8, 1958</b> , that I lost saw the deceased olive on <b>July 7, 1958</b> , and that death occurred at <b>3:45</b> M, from the causes and on the date stated above.   |   |   |  |
| ACTUAL SIGNATURE<br><b>Edward W. Ditto</b>  |   | ADDRESS (Street, city or town, state) DATE SIGNED<br><b>217 W. Washington Street 7/9/58</b>   |  |
| PHYSICIAN'S NAME (Type)<br><b>Edward W. Ditto III, M.D.</b>   |   | <b>Hagerstown, Maryland</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>7/11/1958</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown, Maryland</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>B. Franklin Boyer</b>  |   | ADDRESS<br><b>Hagerstown, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 '58</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. J. Smith</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as a burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8489

## CERTIFICATE OF DEATH

Reg. Dist. No.

08475

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>a.a.</u>                        |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Williamsport</u>   |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Blen Burnie</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Williamsport Sanitarium</u>  |  |   |  | d. STREET ADDRESS<br><u>028-2</u>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Katherine Schmeiser</u>  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><u>July. 17. 1958</u>  |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><u>July 5, 1875</u>                                |  |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Germany</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>USA</u>                |  |
| 13. FATHER'S NAME<br><u>Fritz Cook</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Christina Puse</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  | 17. INFORMANT<br>Address<br><u>Mrs. J. George Johnson</u><br><u>834 E. Belvedere Ave. 12</u>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Failure</u><br><u>443X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u><br>DUE TO (c) <u>14y.</u> |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 days</u>  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <u>19</u>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)  |  |   |  |  |  |  |  |
| 21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>57</u> , to <u>July 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 17</u> , 19 <u>58</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.  |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE<br><u>Paul Haak</u>  |  |   |  | ADDRESS (Street, city or town, state)<br><u>2800 Patomac Street</u>  |  |  |  |
| PHYSICIAN'S NAME (Type)<br><u>PAUL HAAK, M.D.</u>   |  |   |  | DATE SIGNED<br><u>17 July 58</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 22b. DATE THEREOF<br><u>July. 19. 1958</u>  |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Carmel Cem.</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>HENRY SANDER &amp; SONS, INC.</u>  |  |   |  | ADDRESS<br><u>Baltimore Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 21 '58</u>                      |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Alberich</u>  |  |  |  |

## MAYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

8459

## CERTIFICATE OF DEATH

Reg. Dist. No.

08476

|  |   |  |  |   |  |   |  |
|--|---|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   |  |  | c. LENGTH OF STAY IN 1b<br><b>5 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |   |  |  | e. STREET ADDRESS<br><b>1000 Corbett St</b>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>JOSEPH WAYNE SEMLER Jr.</b>   |   |  |  | 4. DATE OF DEATH Month Day Year<br><b>July 18 1958</b>  |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 13, 1958</b> |   | 9. AGE (In years last birthday) yrs.<br><b>5</b> | IF UNDER 1 YEAR<br>Months Days Hours Min.         | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>Joseph Wayne Semler Sr.</b>  |   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Darlene McCleary</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>   |  | 17. INFORMANT<br><b>J.W.Semler Sr.</b>  |  | Address<br><b>Hagerstown Md</b>                   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Intra cranial Hemorrhage</b><br><b>760.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Birth</b><br>DUE TO (c) |   |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town)<br><b>Hagerstown</b>  |  | (County) (State)                                  |  |
| 21. I certify that I attended the deceased from <b>7/13</b> , 19 <b>58</b> , to <b>7/18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>7/17</b> , 19 <b>58</b> , and that death occurred at <b>5:30 A.M.</b> , from the causes and on the date stated above.  |   |  |  |   |  |   |  |
| ACTUAL SIGNATURE<br><b>George Jennings</b>   |   | M.D. <b>136 W. Washington St.</b>  |  | ADDRESS (Street, city or town, state)<br><b>Hagerstown, Md</b>  |  | DATE SIGNED<br><b>7/18/58</b>                     |  |
| PHYSICIAN'S NAME (Type)<br><b>George Jennings</b>  |   |  |  |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b. DATE THEREOF<br><b>7/19/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Maryland</b>   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Walter A. Jones</b>   |   | ADDRESS<br><b>Hagerstown Maryland</b>  |  | 24a. REC'D BY REGISTRAR<br><b>JUL 23 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Alfred Smith</b> |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
CERTIFICATE OF DEATH

|   |  |   |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>JAMES J. JONES     |  | 2. SEX<br>Male                            |  | 3. AGE<br>45                             |  | 4. DATE OF BIRTH<br>1910                     |  | 5. PLACE OF BIRTH<br>Baltimore, Md.       |  |
| 6. OCCUPATION<br>Salesman                 |  | 7. MARITAL STATUS<br>Married              |  | 8. EDUCATION<br>High School              |  | 9. RELIGION<br>Roman Catholic                |  | 10. RACE<br>White                         |  |
| 11. CAUSE OF DEATH<br>Heart Disease       |  | 12. MANNER OF DEATH<br>Natural            |  | 13. PLACE OF DEATH<br>Home               |  | 14. DATE OF DEATH<br>1955                    |  | 15. TIME OF DEATH<br>10:00 AM             |  |
| 16. SIGNATURE OF PHYSICIAN<br>J. J. Jones |  | 17. SIGNATURE OF WITNESSES<br>J. J. Jones |  | 18. SIGNATURE OF DECEASED<br>J. J. Jones |  | 19. SIGNATURE OF FUNERAL HOME<br>J. J. Jones |  | 20. SIGNATURE OF REGISTRAR<br>J. J. Jones |  |

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8460

## CERTIFICATE OF DEATH

08477

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Penna</u> b. COUNTY <u>Franklin</u>                 |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>   |  |  |  | c. LENGTH OF STAY IN 1b <u>4 days</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>  |  |  |  | d. STREET ADDRESS <u>Greencastle 101 West Baltimore</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Oldest Conrad Shanbaltz</u>   |  |  |  | 4. DATE OF DEATH <u>July 21</u> 19 <u>58</u>   |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>August 17, 1889</u>                                      |  |
| 9. AGE (In years last birthday) <u>68</u> yrs.   |  | 10. IF UNDER 1 YEAR Months Days Hours Min. |  | 11. IF UNDER 24 HRS. Months Days Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Inspector</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroader</u>  |  |  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Hampshire Co. West Va.</u>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  |
| 13. FATHER'S NAME <u>George Schanbaltz</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Malinda J. Kidwell</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |  |  | 16. SOCIAL SECURITY NO. <u>None</u>  |  | 17. INFORMANT <u>M. Keith Shanbaltz, Greencastle, Pa</u>                     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>THROMBOSIS OF BASILAR ARTERY</u><br>DUE TO <u>332X</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____<br>DUE TO (c) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)       |  |
| 20f. (City or town) _____ (County) _____ (State) _____   |  |  |  | 20g. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that I attended the deceased from <u>18 July</u> , 19 <u>58</u> , to <u>21 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 July</u> , 19 <u>58</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Greencastle, Penna.</u> DATE SIGNED _____      |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <u>Paul F. Webster</u>  |  |  |  | M.D. <u>Greencastle, Penna.</u>  |  |  |  |
| PHYSICIAN'S NAME (Type) <u>Paul F. Webster M.D.</u>  |  |  |  | <u>Greencastle, Penna.</u>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>7/24/1958</u>         |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Greencastle Franklin Pa</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>  |  |  |  | ADDRESS <u>Greencastle, Pa</u>   |  | 24. REC'D BY REGISTRAR <u>DATE <u>July 23 '58</u></u>                        |  |
| 24b. REGISTRAR'S SIGNATURE <u>Al H. Smith</u>  |  |  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8461

## CERTIFICATE OF DEATH

08478

Reg. Dist. No.

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>03</b> <b>Hagerstown</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Martin Manor Nursing Home</b>   |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>E</b> Last <b>Sheaffer</b>   |                                  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>30</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 14, 1869</b> |
| 9. AGE (In years last birthday)<br><b>88</b> yrs.  |                                  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Car Repairman P.R.R.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>David Sheaffer</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Annie Reitzell</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>unknown</b>  |  |
| 17. INFORMANT<br><b>Clyde R. Sheaffer Sr.,</b> Address <b>Dayton 16, Ohio</b>  |                                  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease</b><br>DUE TO <b>Benign Hypertrophy</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio-sclerotic heart disease</b><br>DUE TO (c) <b>Benign Hypertrophy</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b><br><b>3 mo</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>                               |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>7-1-58</b> to <b>7-30-58</b> , that I last saw the deceased alive on <b>7-30-58</b> at <b>12:30</b> M., from the causes and on the date stated above.   |                                  |  |  |
| ACTUAL SIGNATURE<br><b>H. E. Smith</b>   |                                  | ADDRESS (Specify city or town, state)<br><b>Hagerstown Md</b>  |  |
| PHYSICIAN'S NAME (Type)<br><b>H. E. Smith</b>  |                                  | DATE SIGNED<br><b>7/30/58</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                                  | 22b. DATE THEREOF<br><b>8-4-58</b>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Camp Hill</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Camp Hill Pa.</b>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Fred W. Kraiss</b>  |                                  | ADDRESS<br><b>Hagerstown, Md.</b>  |  |
| 24a. REC'D BY REGISTRAR<br><b>DATE AUG 1 '58</b>   |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Alfred Smith</b>  |  |

*Chlorophytum complanatum*

1. The first  
 2. The second  
 3. The third  
 4. The fourth  
 5. The fifth  
 6. The sixth  
 7. The seventh  
 8. The eighth  
 9. The ninth  
 10. The tenth  
 11. The eleventh  
 12. The twelfth  
 13. The thirteenth  
 14. The fourteenth  
 15. The fifteenth  
 16. The sixteenth  
 17. The seventeenth  
 18. The eighteenth  
 19. The nineteenth  
 20. The twentieth  
 21. The twenty-first  
 22. The twenty-second  
 23. The twenty-third  
 24. The twenty-fourth  
 25. The twenty-fifth  
 26. The twenty-sixth  
 27. The twenty-seventh  
 28. The twenty-eighth  
 29. The twenty-ninth  
 30. The thirtieth  
 31. The thirty-first  
 32. The thirty-second  
 33. The thirty-third  
 34. The thirty-fourth  
 35. The thirty-fifth  
 36. The thirty-sixth  
 37. The thirty-seventh  
 38. The thirty-eighth  
 39. The thirty-ninth  
 40. The fortieth  
 41. The forty-first  
 42. The forty-second  
 43. The forty-third  
 44. The forty-fourth  
 45. The forty-fifth  
 46. The forty-sixth  
 47. The forty-seventh  
 48. The forty-eighth  
 49. The forty-ninth  
 50. The fiftieth  
 51. The fifty-first  
 52. The fifty-second  
 53. The fifty-third  
 54. The fifty-fourth  
 55. The fifty-fifth  
 56. The fifty-sixth  
 57. The fifty-seventh  
 58. The fifty-eighth  
 59. The fifty-ninth  
 60. The sixtieth  
 61. The sixty-first  
 62. The sixty-second  
 63. The sixty-third  
 64. The sixty-fourth  
 65. The sixty-fifth  
 66. The sixty-sixth  
 67. The sixty-seventh  
 68. The sixty-eighth  
 69. The sixty-ninth  
 70. The seventieth  
 71. The seventy-first  
 72. The seventy-second  
 73. The seventy-third  
 74. The seventy-fourth  
 75. The seventy-fifth  
 76. The seventy-sixth  
 77. The seventy-seventh  
 78. The seventy-eighth  
 79. The seventy-ninth  
 80. The eightieth  
 81. The eighty-first  
 82. The eighty-second  
 83. The eighty-third  
 84. The eighty-fourth  
 85. The eighty-fifth  
 86. The eighty-sixth  
 87. The eighty-seventh  
 88. The eighty-eighth  
 89. The eighty-ninth  
 90. The ninetieth  
 91. The ninety-first  
 92. The ninety-second  
 93. The ninety-third  
 94. The ninety-fourth  
 95. The ninety-fifth  
 96. The ninety-sixth  
 97. The ninety-seventh  
 98. The ninety-eighth  
 99. The ninety-ninth  
 100. The hundredth

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

8462

1

08479

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Washington</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |   | c. LENGTH OF STAY IN TB<br><b>40 Yrs.</b>   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>425 Jefferson St.,</b>  |   | e. STREET ADDRESS<br><b>425 Jefferson St.,</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elva</b> Middle <b>Elizabeth</b> Last <b>Smith</b>   |   | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>8</b> Year <b>19 58</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 16, 1895</b>                               |
| 9. AGE (In years last birthday)<br><b>63</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Clear Spring, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>John Drury</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary E. Forsythe</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  |
| 17. INFORMANT<br><b>George Smith</b>   |   | Address<br><b>Hagerstown, Md.</b>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Thrombosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>(c) <b>years</b>    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>20 minutes</b>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>none</b>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>July 7, 1958</b> to <b>July 7, 1958</b> , that I last saw the deceased alive on <b>July 7, 1958</b> , and that death occurred at <b>11:50 AM</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>135 NO. POTOMAC ST. HAGERSTOWN, MARYLAND</b><br>DATE SIGNED <b>7/11/58</b> |   |   |  |
| ACTUAL SIGNATURE<br><b>J. D. WILSON, M.D.</b>  |   | M.D.  |  |
| PHYSICIAN'S NAME (Type)  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   | 22b. DATE THEREOF<br><b>7/11/58</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rose Hill Cemetery</b>   | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Fred W. Kraiss</b>  |   | ADDRESS<br><b>Hagerstown, Md.</b>   |  |
| 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 14 '58</b>  |   | 24b. REGISTRAR'S SIGNATURE<br><b>W. A. Leach</b>  |  |



CERTIFICATE OF DEATH

1900

|                        |  |                            |  |
|------------------------|--|----------------------------|--|
| Name of Deceased       |  | John J. Smith              |  |
| Age                    |  | 45                         |  |
| Sex                    |  | Male                       |  |
| Race                   |  | Caucasian                  |  |
| Date of Death          |  | Jan. 15, 1900              |  |
| Place of Death         |  | Home                       |  |
| Cause of Death         |  | Heart Disease              |  |
| Disease                |  | Myocarditis                |  |
| Duration of Illness    |  | 10 days                    |  |
| Occupation             |  | Carpenter                  |  |
| Signature of Physician |  | [Signature]                |  |
| Signature of Registrar |  | [Signature]                |  |
| Date of Registration   |  | Jan. 16, 1900              |  |
| Place of Registration  |  | Bureau of Vital Statistics |  |

## 8490 CERTIFICATE OF DEATH

08480

Reg. Dist. No.

|  |                               |   |                                       |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>                       |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maugansville</b>   |                               | c. LENGTH OF STAY IN 1b <b>21 days</b>  |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mennonite Home</b>   |                               | 1 d. STREET ADDRESS <b>20 Summit Ave.</b>   |                                       |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |   |                                       |
| 3. NAME OF DECEASED (Type or print) <b>Margaret</b> First Middle Last <b>Southgate</b>   |                               | 4. DATE OF DEATH Month <b>July</b> Day <b>27</b> Year <b>1958</b>   |                                       |
| 5. SEX <b>Female</b>   | 6. COLOR OR RACE <b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>            | 8. DATE OF BIRTH <b>June 21, 1868</b> |
| 9. AGE (In years last birthday) <b>90</b> yrs.   |                               | IF UNDER 1 YEAR Months Days Hours Min.  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>   |                                       |
| 11. BIRTHPLACE (State or foreign country) <b>Johnsville Md.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?  |                                       |
| 13. FATHER'S NAME <b>Ruben Southgate</b>   |                               | 14. MOTHER'S MAIDEN NAME <b>Jeanette Shivers</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>  |                               | 16. SOCIAL SECURITY NO. <b>---</b>  |                                       |
| 17. INFORMANT Address <b>Mrs. Cora Hartford Hagerstown Md.</b>   |                               |   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Vascular accident probably coronary thrombosis</b><br>DUE TO <b>Arteriosclerosis generalis</b><br>(b)<br>DUE TO<br>(c)<br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                               |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                               |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>  |                               | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that I attended the deceased from <b>June 6, 1958</b> , to <b>6-27, 1958</b> , that I last saw the deceased alive on <b>6-27, 1958</b> , and that death occurred at <b>7:30</b> M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>7-28-58</b> DATE SIGNED  |                               |   |                                       |
| ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.  |                               |   |                                       |
| PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>  |                               |   |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 22b. DATE THEREOF <b>7-29-58</b>  |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>  |                               | 22d. LOCATION (City, town, or county) (State) <b>Smithsburg Md.</b>   |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>Minnich Funeral Home</b> ADDRESS <b>Hagerstown Md.</b>   |                               | 24a. REC'D BY REGISTRAR <b>JUL 31 '58</b> DATE  |                                       |
| 24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>  |                               |   |                                       |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8463

CERTIFICATE OF DEATH

08481

Reg. Dist. No.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington County Hospital</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| d. STREET ADDRESS<br><b>2245 Beverly Drive</b>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>James Daniel Stickell</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>31</b> Year <b>1958</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Dec. 2, 1910</b>                                |  |
| 9. AGE (In years last birthday)<br><b>47</b> yrs.  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>repairman</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>electricial</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Hagerstown Md.</b>     |  |
| 13. FATHER'S NAME<br><b>Ralph Y. Stickell</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Florence Spigler</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>214-10-5362</b>  |  | 17. INFORMANT<br><b>Mrs. M. Genevieve Stickell Hagerstown</b>  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b><br><b>153.3</b> DUE TO <b>of abdomen, liver &amp; chest</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of sigmoid colon</b><br>(c) <b>15 months</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b> |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>March 21, 1953</b> , to <b>July 31, 1958</b> , that I last saw the deceased alive on <b>July 31, 1958</b> , and that death occurred at <b>6:20 PM</b> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>L. L. Packer, Jr. M.D.</b>   |  |  |  | ADDRESS (Street, city or town, state) <b>1145 W. Washington St. Hagerstown, Md.</b>  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>L. L. PACKER, JR., M.D.</b>   |  |  |  | DATE SIGNED <b>8/1/58</b>  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>8-3-58</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Rest Haven Cemetery</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Hagerstown Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home</b>  |  |  |  | ADDRESS<br><b>Hagerstown Md.</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>AUG 4 '58</b>                       |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>W. H. Beach</b>   |  |  |  |

2000



8491

CERTIFICATE OF DEATH

Reg. Dist. No. 08482

|  |                               |  |  |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>WASHINGTON</b> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CONOCOCHAGUE</b>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>03 HAGERSTOWN</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GATE WAY NURSING HOME</b>  |                               | d. STREET ADDRESS <b>931 A LANVALE STREET</b>  |  |
| 3. NAME OF DECEASED (Type or print) First <b>HARRIET</b> Middle <b>V.</b> Last <b>STOCKSLAGER</b>  |                               | 4. DATE OF DEATH Month <b>JULY</b> Day <b>19</b> Year <b>1958</b>  |  |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>AUGUST 28 1866</b> |
| 9. AGE (In years last birthday) <b>91</b> yrs.   |                               | 10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE KEEPER</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>NEAR MYERSVILLE FRED.CO.MD. U.S.A.</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>UNKNOWN KOOGLE</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>ELLA FOX</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>   |                               | 16. SOCIAL SECURITY NO. <b>NONE</b>  |  |
| 17. INFORMANT <b>MRS. ALTON KLINE BOONSBORO MD. R. 2</b>   |                               | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.0</b><br>DUE TO <b>arteriosclerosis and general arterio-sclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>heart disease</b><br>DUE TO (c) <b>10 yrs</b> |                               | INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Two year tuberculosis</b>   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <b>19</b>   |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <b>Aug 1, 1956</b> , to <b>July 20, 1958</b> , that I last saw the deceased alive on <b>June 25, 1958</b> , and that death occurred at <b>9:00</b> M, from the causes and on the date stated above.  |                               |  |  |
| ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D.   |                               | ADDRESS (Street, city or town, state) <b>217 W. Washington St. Hagerstown, Maryland</b>  |  |
| PHYSICIAN'S NAME (Type) <b>Edward W. Ditto M.D.</b>  |                               | DATE SIGNED <b>7/26/58</b>   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>  |                               | 22b. DATE THEREOF <b>JULY 22 1958</b>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>   |                               | 22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Best</b>   |                               | ADDRESS <b>Boonsboro Md</b>  |  |
| 24a. REC'D BY REGISTRAR <b>JUL 24 '58</b>  |                               | 24b. REGISTRAR'S SIGNATURE <b>W. E. Seach</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8464  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>o. COUNTY <u>WASHINGTON</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>               |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HAGERSTOWN</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>5 days</u>  |  |   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>WASHINGTON COUNTY HOSPITAL</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Brenda</u> Middle <u>RAY</u> Last <u>STRITE</u>   |  |   |  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>22</u> Year <u>1958</u>   |  |   |   |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>white</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 8. DATE OF BIRTH<br><u>July 17 1958</u>                                     |   |
| 9. AGE (In years lost birthday)<br><u>5</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> |  | IF UNDER 24 HRS.<br>Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>  |  |   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>NONE</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |   |  |   |  |   |   |
| 13. FATHER'S NAME<br><u>Clarence STRITE</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary GRACE Clugston</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>   |  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>Clarence STRITE</u>   |  | Address<br><u>HAGERSTOWN RT#6 Md.</u>                                       |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>754.5 Congenital heart disease</u><br>DUE TO (b) <u>(Type undiagnosed)</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>(Type undiagnosed)</u>          |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>—</u> a. m. <u>19</u> p. m. <u>—</u>  |  |   |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |   |
|   |  |   |  | 20f. (City or town)   |  | (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>July 17, 1958</u> to <u>July 22, 1958</u> , that I last saw the deceased alive on <u>July 21, 1958</u> , and that death occurred at <u>1:45 PM</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>217 W. Washington Street</u> DATE SIGNED <u>7/22/58</u> |  |   |  |   |  |   |   |
| ACTUAL SIGNATURE <u>Edward W. Ditto</u> M.D. <u>217 W. Washington Street</u>  |  |   |  |   |  |   |   |
| PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u> <u>Hagerstown, Maryland</u> <u>7/22/58</u>   |  |   |  |   |  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>REMOVAL</u>   |  | 22b. DATE THEREOF<br><u>7/22/58</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Methodist Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Chambersburg Penna.</u> |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Chambersburg</u>   |  |   |  | ADDRESS<br><u>Hagerstown Md.</u>  |  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 24 '58</u>                           |   |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>Albrecht</u>   |  |   |   |

2081265XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

|                           |  |                            |  |                            |  |                        |  |                             |  |
|---------------------------|--|----------------------------|--|----------------------------|--|------------------------|--|-----------------------------|--|
| 1. NAME OF DECEASED       |  | 2. SEX                     |  | 3. AGE                     |  | 4. DATE OF BIRTH       |  | 5. PLACE OF BIRTH           |  |
| 6. OCCUPATION             |  | 7. MARITAL STATUS          |  | 8. COLOR                   |  | 9. RELIGION            |  | 10. EDUCATION               |  |
| 11. DATE OF DEATH         |  | 12. TIME OF DEATH          |  | 13. PLACE OF DEATH         |  | 14. CAUSE OF DEATH     |  | 15. MANNER OF DEATH         |  |
| 16. SIGNATURE OF DECEASED |  | 17. SIGNATURE OF WITNESSES |  | 18. SIGNATURE OF PHYSICIAN |  | 19. SIGNATURE OF CLERK |  | 20. SIGNATURE OF REGISTRAR  |  |
| 21. SIGNATURE OF DECEASED |  | 22. SIGNATURE OF WITNESSES |  | 23. SIGNATURE OF PHYSICIAN |  | 24. SIGNATURE OF CLERK |  | 25. SIGNATURE OF REGISTRAR  |  |
| 26. SIGNATURE OF DECEASED |  | 27. SIGNATURE OF WITNESSES |  | 28. SIGNATURE OF PHYSICIAN |  | 29. SIGNATURE OF CLERK |  | 30. SIGNATURE OF REGISTRAR  |  |
| 31. SIGNATURE OF DECEASED |  | 32. SIGNATURE OF WITNESSES |  | 33. SIGNATURE OF PHYSICIAN |  | 34. SIGNATURE OF CLERK |  | 35. SIGNATURE OF REGISTRAR  |  |
| 36. SIGNATURE OF DECEASED |  | 37. SIGNATURE OF WITNESSES |  | 38. SIGNATURE OF PHYSICIAN |  | 39. SIGNATURE OF CLERK |  | 40. SIGNATURE OF REGISTRAR  |  |
| 41. SIGNATURE OF DECEASED |  | 42. SIGNATURE OF WITNESSES |  | 43. SIGNATURE OF PHYSICIAN |  | 44. SIGNATURE OF CLERK |  | 45. SIGNATURE OF REGISTRAR  |  |
| 46. SIGNATURE OF DECEASED |  | 47. SIGNATURE OF WITNESSES |  | 48. SIGNATURE OF PHYSICIAN |  | 49. SIGNATURE OF CLERK |  | 50. SIGNATURE OF REGISTRAR  |  |
| 51. SIGNATURE OF DECEASED |  | 52. SIGNATURE OF WITNESSES |  | 53. SIGNATURE OF PHYSICIAN |  | 54. SIGNATURE OF CLERK |  | 55. SIGNATURE OF REGISTRAR  |  |
| 56. SIGNATURE OF DECEASED |  | 57. SIGNATURE OF WITNESSES |  | 58. SIGNATURE OF PHYSICIAN |  | 59. SIGNATURE OF CLERK |  | 60. SIGNATURE OF REGISTRAR  |  |
| 61. SIGNATURE OF DECEASED |  | 62. SIGNATURE OF WITNESSES |  | 63. SIGNATURE OF PHYSICIAN |  | 64. SIGNATURE OF CLERK |  | 65. SIGNATURE OF REGISTRAR  |  |
| 66. SIGNATURE OF DECEASED |  | 67. SIGNATURE OF WITNESSES |  | 68. SIGNATURE OF PHYSICIAN |  | 69. SIGNATURE OF CLERK |  | 70. SIGNATURE OF REGISTRAR  |  |
| 71. SIGNATURE OF DECEASED |  | 72. SIGNATURE OF WITNESSES |  | 73. SIGNATURE OF PHYSICIAN |  | 74. SIGNATURE OF CLERK |  | 75. SIGNATURE OF REGISTRAR  |  |
| 76. SIGNATURE OF DECEASED |  | 77. SIGNATURE OF WITNESSES |  | 78. SIGNATURE OF PHYSICIAN |  | 79. SIGNATURE OF CLERK |  | 80. SIGNATURE OF REGISTRAR  |  |
| 81. SIGNATURE OF DECEASED |  | 82. SIGNATURE OF WITNESSES |  | 83. SIGNATURE OF PHYSICIAN |  | 84. SIGNATURE OF CLERK |  | 85. SIGNATURE OF REGISTRAR  |  |
| 86. SIGNATURE OF DECEASED |  | 87. SIGNATURE OF WITNESSES |  | 88. SIGNATURE OF PHYSICIAN |  | 89. SIGNATURE OF CLERK |  | 90. SIGNATURE OF REGISTRAR  |  |
| 91. SIGNATURE OF DECEASED |  | 92. SIGNATURE OF WITNESSES |  | 93. SIGNATURE OF PHYSICIAN |  | 94. SIGNATURE OF CLERK |  | 95. SIGNATURE OF REGISTRAR  |  |
| 96. SIGNATURE OF DECEASED |  | 97. SIGNATURE OF WITNESSES |  | 98. SIGNATURE OF PHYSICIAN |  | 99. SIGNATURE OF CLERK |  | 100. SIGNATURE OF REGISTRAR |  |

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 This certificate is to be filled out by the attending physician or the registrar of the town or city where the death occurred.  
 The cause of death should be stated in full, and the manner of death should be stated as natural, accidental, or suicidal.  
 The date of death should be stated in full, and the time of death should be stated if known.  
 The place of death should be stated in full, and the name of the physician should be stated if known.  
 The name of the deceased should be stated in full, and the sex and age should be stated.  
 The occupation of the deceased should be stated if known, and the marital status should be stated.  
 The color of the deceased should be stated, and the religion should be stated if known.  
 The education of the deceased should be stated if known.  
 The signature of the deceased should be stated if known, and the signature of the witnesses should be stated.  
 The signature of the physician should be stated, and the signature of the clerk should be stated.  
 The signature of the registrar should be stated.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8465

Item 14 Film G231 7/18/58

## CERTIFICATE OF DEATH

Reg. Dist. No.

08484

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u>                  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lagerstown</u>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> 75X-3 ✓  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Conv. Home</u>  |  |  |  | d. STREET ADDRESS <u>216 E. Baltimore St</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>L.</u> Last <u>Strite</u>  |  |  |  | 4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1958</u>  |  |   |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>White</u>          |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>8/9/1872</u>  |  |
| 9. AGE (In years lost birthday) <u>85</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min. |  | IF UNDER 24 HRS. Months Days Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>  |  | 11. BIRTHPLACE (State or foreign country) <u>Antietam Twp. Franklin Co</u>                    |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |  |  |  |  |  |   |  |
| 13. FATHER'S NAME <u>Christian Strite</u>   |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Annie Shively</u>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO. <u>Mr. Norman Strite, Albany, N.Y.</u>   |  |   |  |
| 17. INFORMANT Address <u>Albany, N.Y.</u>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>332X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Unknown</u> |  |  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. p. m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                        |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |  |   |  |
| 21. I certify that I attended the deceased from <u>17 June</u> , 19 <u>58</u> , to <u>17 July</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 July</u> , 19 <u>58</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <u>E. Edgar Handlank</u> M.D.  |  |  |  | ADDRESS (Street, city or town, state) <u>115 W. Wash</u>   |  |   |  |
| DATE SIGNED <u>7/14/58</u>  |  |  |  |  |  |   |  |
| PHYSICIAN'S NAME (Type) <u>Elder St. Oach later Hagon, Lower Md</u>   |  |  |  |  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 22b. DATE THEREOF <u>July 16, 1958</u> |  | 22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Greencastle Antietam Twp. Franklin Co Pa</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman, Greencastle, Pa</u>  |  |  |  | 24. REG'D BY REGISTRAR <u>JUL 16 1958</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8492 CERTIFICATE OF DEATH

08485

Reg. Dist. No.

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL HAGERSTOWN</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>3 WEEKS</u>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br><u>GATEWAY NURSING HOME</u>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>AGNES</u> Middle <u>MAE</u> Last <u>SWOPE</u>   |                                  | 4. DATE OF DEATH<br>Month <u>7</u> Day <u>8</u> Year <u>1958</u>  |   |
| 5. SEX<br><u>FEMALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JAN 31, 1878</u> |
| 9. AGE (In years last birthday)<br><u>80</u> yrs.   |                                  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWORK</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>WILLIAM PENNER</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>MARY BRIDENDOLPH</u>   |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |   |
| 17. INFORMANT<br><u>MRS. EVELYN JOHNSON</u>   |                                  | Address<br><u>CLEAR SPRING, MD.</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arterial Sclerosis</u><br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u><br>DUE TO (c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs.</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I attended the deceased from <u>Dec. 26, 1958</u> to <u>July 8, 1958</u> , that I last saw the deceased alive on <u>July 7, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.   |                                  |   |   |
| ACTUAL SIGNATURE <u>David R. Brewer</u> M.D.  |                                  | ADDRESS (Street, city or town, state) <u>Clear Spring Md.</u>   |   |
| DATE SIGNED <u>7/9/58</u>   |                                  |   |   |
| PHYSICIAN'S NAME (Type) <u>David R. Brewer</u>  |                                  |   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 22b. DATE THEREOF<br><u>7/12/58</u>   |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>ST. PETERS LUTHREN</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>CLEAR SPRING, MD.</u>   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>John F. Clark</u>  |                                  | ADDRESS<br><u>CLEAR SPRING, MD.</u>   |   |
| 24a. REC'D BY REGISTRAR<br><u>  </u>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><u>  </u>   |   |
| DATE <u>JUL 14 '58</u>  |                                  |   |   |

3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

: 8466

## CERTIFICATE OF DEATH

Reg. Dist. No.

08488

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>                 |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>5 weeks</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Garlock Nursing Home</b>  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Arthur</b> Middle <b>Lee</b> Last <b>Towson, Sr.</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>2</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>                                     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 6, 1866</b>   |  |
| 9. AGE (In years last birthday) yrs.<br><b>91</b>  |  | IF UNDER 1 YEAR<br>Months <b>9</b> Days <b>1</b> Hours <b>1</b> Min. |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>horticulturist</b>                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>fruit</b>                                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Smithsburg, Md.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 13. FATHER'S NAME<br><b>Jacob Tolley</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Henreitta Bishop</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  | 16. SOCIAL SECURITY NO.<br><b>no</b>                                 |  | 17. INFORMANT<br><b>Mrs. Julia P. Towson, Smithsburg, Md.</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>420.0</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Arterio Sclerotic Heart</b> DUE TO<br>(c) <b>Generalized Arterio Sclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hours</b><br><b>20 yrs</b><br><b>20 yrs</b> |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>0.31</b> p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)              |  |
| 20f. (City or town)<br><b>Smithsburg</b>   |  |  |  | 20g. (County)<br><b>Md.</b>  |  | 20h. (State)<br><b>Md.</b>  |  |
| 21. I certify that I attended the deceased from <b>May 29, 1958</b> , to <b>July 2, 1958</b> , that I last saw the deceased alive on <b>July 2, 1958</b> , and that death occurred at <b>Smithsburg, Md.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>3204 main st Smithsburg Md</b> DATE SIGNED <b>7/3/58</b>  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>A. G. Kohler</b> M.D.  |  |  |  | PHYSICIAN'S NAME (Type) <b>A. G. KOHLER Smithsburg Md</b>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>   |  | 22b. DATE THEREOF<br><b>July 4, 1958</b>                             |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mausoleum</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Smithsburg, Md.</b>             |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Minnich Funeral Home, Smithsburg, Md.</b>   |  |  |  | 24a. REC'D BY REGISTRAR<br><b>DATE Jul 7 '58</b>   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Overman</b>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8493

## CERTIFICATE OF DEATH

Reg. Dist. No.

08487

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>               |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hancock</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>Life</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>X Hancock</b> |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Home</b>   |  |  |  | d. STREET ADDRESS   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Mary</b> Middle <b>Alice</b> Last <b>Triece</b>  |  |  |  | 4. DATE OF DEATH<br>Month <b>7</b> Day <b>2</b> Year <b>19 58</b>   |  |  |   |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>                     |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>3.28.1863</b>   |   |
| 9. AGE (In years last birthday)<br><b>95</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>3</b> |  | IF UNDER 24 HRS.<br>Hours <b>3</b> Min.   |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Washington County Md.</b>                            |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Joseph A Vannosdeln</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Susan Rowland</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT<br><b>Susan J Bohler Hancock Md.</b>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br><b>420.1</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b><br>DUE TO (c) |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Semile Debility</b>   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |   |
| 20c. TIME OF INJURY<br>Month <b>19</b> Day <b>19</b> Year <b>19</b><br>Hour a. m. p. m.   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |   |
| 20f. (City or town)<br><b>Blairsville Indiana Penna.</b>  |  |  |  | 20g. (County) (State)   |  |  |   |
| 21. I certify that I attended the deceased from <b>June 1950</b> to <b>6-24, 1958</b> , that I last saw the deceased alive on <b>6-24, 1958</b> , and that death occurred at <b>5 A</b> M, from the causes and on the date stated above.  |  |  |  |   |  |  |   |
| ACTUAL SIGNATURE<br><b>Herbert R. Tobias</b>  |  |  |  | ADDRESS (Street, city or town, state)<br><b>Berkeley Springs W. Va.</b>   |  |  |   |
| DATE SIGNED<br><b>7-3-58</b>  |  |  |  |   |  |  |   |
| PHYSICIAN'S NAME (Type)<br><b>Howard J. Stone</b>   |  |  |  |   |  |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b. DATE THEREOF<br><b>7.5.58</b>               |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Blaisville Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Blairsville Indiana Penna.</b>                   |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Howard J. Stone</b>  |  |  |  | ADDRESS<br><b>Hancock Md</b>  |  | 24a. REC'D BY REGISTRAR<br><b>DATE JUL 7 '58</b>   |   |
|   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Attest</b>   |  |  |   |



1

M

8467

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

DR. WILLIAM BREWER, M.D.

Reg. Dist. No. 88 302

|  |                        |  |                               |
|--|------------------------|--|-------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY Washington MARYLAND   |                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE Penna b. COUNTY Franklin                               |                               |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown  |                        | c. LENGTH OF STAY IN 1b 17 hrs.  |                               |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital  |                        | d. STREET ADDRESS Zullinger  |                               |
| 3. NAME OF DECEASED<br>First James Middle Cary Last Walker   |                        | 4. DATE OF DEATH<br>Month July Day 31 Year 1958  |                               |
| 5. SEX Male  | 6. COLOR OR RACE Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JAN. 1, 1881 |
| 9. AGE (In years last birthday) 77 yrs.  |                        | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PREACHER   |                        | 10b. KIND OF BUSINESS OR INDUSTRY RETIRED  |                               |
| 11. BIRTHPLACE (State or foreign country) MARTINSBURG W.VA.  |                        | 12. CITIZEN OF WHAT COUNTRY? U.S.  |                               |
| 13. FATHER'S NAME JOHN W. WALKER   |                        | 14. MOTHER'S MAIDEN NAME MARY MC CLELER  |                               |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO  |                        | 16. SOCIAL SECURITY NO. NONE   |                               |
| 17. INFORMANT MRS. MAUDE WALKER WAYNESBORO R.H.3   |                        | Address  |                               |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Mural thrombus of right ventricle with extension into pulmonary artery<br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) Myocardial dilatation with passive congestion of circulation<br>DUE TO<br>(c) Arteriosclerotic Cardiovascular disease |                        | INTERVAL BETWEEN ONSET AND DEATH<br>Several weeks<br>6 months<br>10 years  |                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                        | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               |
| Generalized arteriosclerosis and senility  |                        |  |                               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                        | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. 11. p. m. 19   |                        | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                               |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                        | 20f. (City or town) (County) (State)   |                               |
| 21. I certify that I attended the deceased from June 30, 1958, to July 31, 1958, that I last saw the deceased alive on July 31, 1958, and that death occurred at 1:30 PM, from the causes and on the date stated above.  |                        |  |                               |
| ACTUAL SIGNATURE W. C. Brewer, M.D.  |                        | ADDRESS (Street, city or town, state) 359 E. Baltimore St., Greencastle Penna.   |                               |
| DATE SIGNED 8/1/58   |                        |  |                               |
| PHYSICIAN'S NAME (Type) W. C. Brewer, M.D.   |                        |  |                               |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |                        | 22b. DATE THEREOF AUG. 2, 1958   |                               |
| 22c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY   |                        | 22d. LOCATION (City, town, or county) (State) MARTINSBURG, W.VA.   |                               |
| 23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS<br>ANDREW K. COFFMAN 40 E. Antietam St.<br>Hagerstown md  |                        | 24a. REC'D BY REGISTRAR DATE AUG 4 '58   |                               |
| 24b. REGISTRAR'S SIGNATURE   |                        |  |                               |

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DR. WILLIAM BREWER

JAN. 1, 1881

MARY MC CLELLAN

RETIRED

PREACHER

JOHN W. WALKER

WIFE

WIFE

MRS. MAUDE WALKER WYSSBROOK

GREEN HILL CEMETERY

MARTIN BOURG, W.V.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08489

Reg. Dist. No.

8468

|  |  |  |  |
|--|--|--|--|
| 1. PLACE OF DEATH<br>o. COUNTY <u>Washington</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u><br>c. LENGTH OF STAY IN 1b <u>Life</u><br>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>663 S. Potomac St.</u>  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Washington</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u><br>d. STREET ADDRESS <u>1663 S. Potomac St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Mary Kate Williams</u><br>First Middle Last<br>4. DATE OF DEATH <u>July 16 19 58</u><br>Month Day Year   |  | 5. SEX <u>Female</u><br>6. COLOR OR RACE <u>White</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <u>Dec. 26, 1885</u><br>9. AGE (In years last birthday) <u>72</u> yrs.<br>IF UNDER 1 YEAR: Months Days Hours Min.<br>IF UNDER 24 HRS.                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u><br>11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u><br>12. CITIZEN OF WHAT COUNTRY?  |  | 13. FATHER'S NAME <u>Victor E. Gruber</u><br>14. MOTHER'S MAIDEN NAME <u>Lillian Stauffer</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u><br>(If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <u>---</u><br>17. INFORMANT <u>Grover C. Williams</u> Address <u>Hagerstown Md.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>DUE TO (b) <u>Hypertensive-arteriosclerotic heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>---</u>                    |  | INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u><br><u>16 years</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. p. m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>5/23, 1942</u> to <u>7/16, 1958</u> that I last saw the deceased alive on <u>7/16, 1958</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>154 West Washington St., Hagerstown Md.</u><br>DATE SIGNED <u>7:17:58</u> |  |  |  |
| ACTUAL SIGNATURE <u>John H. Hornbaker</u><br>PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>  |  | M.D. <u>154 West Washington St., Hagerstown Md.</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 22b. DATE THEREOF <u>7-18-58</u>   |  |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u> ADDRESS <u>Hagerstown Md.</u>   |  | 24a. REC'D BY REGISTRAR <u>DATE JUL 21 '58</u><br>24b. REGISTRAR'S SIGNATURE <u>Al. Search</u>   |  |





8469

CERTIFICATE OF DEATH

08490

Reg. Dist. No.

|   |   |  |   |   |  |   |  |
|---|---|--|---|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> MARYLAND   |   |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>b. COUNTY <b>Frederick</b> STATE <b>Maryland</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Hagerstown</b>   |   |  |   | c. LENGTH OF STAY IN 1b<br><b>4 days</b>  |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Washington Co. Hospital</b>  |   |  |   | d. STREET ADDRESS<br><b>Foxville</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BEUNA</b> Middle <b>V.</b> Last <b>WOLFE</b>  |   |  |   | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>12</b> Year <b>1958</b>  |  |   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>May 2, 1886</b>  | 9. AGE (In years last birthday) yrs.<br><b>72</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.          | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Merchant</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Gen. Mdse.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Frederick Co. Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |
| 13. FATHER'S NAME<br><b>Jonathon Wolfe</b>  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Blickenstaff</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |   | 16. SOCIAL SECURITY NO.<br><b>218-14-7204</b>  |   | 17. INFORMANT<br>Address <b>Irl. Sensenabaugh, Smithsburg, Md. Rt. #1</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>158X acute coronary occlusion</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Retrospective of malignancy</b><br>DUE TO (c) <b>Generalized arteriosclerosis</b> |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 mts</b><br><b>6 mths</b><br><b>10 yrs</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour o. m. p. m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town)   | (County)  | (State)  |   |  |
| 21. I certify that I attended the deceased from <b>Mar 12, 1958</b> to <b>July 12, 1958</b> , that I last saw the deceased alive on <b>July 12, 1958</b> , and that death occurred at <b>Smithsburg</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>3 South main St Smithsburg md</b><br>DATE SIGNED <b>7/12/58</b>         |   |  |   |   |  |   |  |
| ACTUAL SIGNATURE<br><b>G.A. Kohler</b>  |   | M.D. <b>3 South main St Smithsburg md</b>  |   |   |  |   |  |
| PHYSICIAN'S NAME (Type)<br><b>G.A. Kohler</b>   |   |  |   |   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>July 14, 1958</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Reformed</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Wolfsville, Fred. Co. Md.</b> |   |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Paul F. Bittle</b>   |   |  | ADDRESS<br><b>Myersville, Md.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 15 1958</b> | 24b. REGISTRAR'S SIGNATURE<br><b>Alfred</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

8470

08491  
302

|   |                                  |  |                                       |
|---|----------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Washington</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>             |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Hagerstown</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>3 Days</u>   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Wash. County Hospital</u>  |                                  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                       |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>ANNA CLINE WINTERS*WOLFE</u>  |                                  | 4. DATE OF DEATH Month Day Year<br><u>July 1 1958 19</u>   |                                       |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 9 1877</u> |
| 9. AGE (In years last birthday) yrs.<br><u>81</u>   |                                  | IF UNDER 1 YEAR Months Days Hours Min.<br><u>19</u>  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><u>Fiddlersburg Wash. Co Md.</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                                       |
| 13. FATHER'S NAME<br><u>Samuel Cline</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Laura</u>   |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>   |                                       |
| 17. INFORMANT<br><u>Harvey Winters 73 Madison Ave</u>   |                                  | Address<br><u>Hagerstown Md.</u>   |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary insufficiency and chronic heart failure</u><br>420.0 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Arteriosclerotic heart disease</u><br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Arthritis, rheumatoid involving spine principally</u> |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><u>2 years (certain)</u>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that I attended the deceased from <u>June 29</u> , 19 <u>58</u> , to <u>July 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>58</u> , and that death occurred at <u>6:55 P.M.</u> from the causes and on the date stated above.<br>DST ADDRESS (Street, city or town, state) DATE SIGNED<br>ACTUAL SIGNATURE <u>W. J. Layman, M.D.</u> M.D. <u>100 Professional Arts Bldg. 7/2/58</u><br>PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u> <u>Hagerstown</u> <u>Maryland</u>  |                                  |  |                                       |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 22b. DATE THEREOF<br><u>7/3/58</u>   |                                       |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>Rose Hill Cemetery</u>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><u>Hagerstown Wash. Co Md.</u>  |                                       |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Andrew K. Coffman</u>  |                                  | 24a. REC'D BY REGISTRAR<br>DATE <u>JUL 8 '58</u>   |                                       |
| 24b. REGISTRAR'S SIGNATURE<br><u>W. J. Layman</u>   |                                  |  |                                       |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

08492

Reg. Dist. No.

8471

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Washington</b> <b>MARYLAND</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>            |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Williamsport</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>6 days</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Williamsport Sanitarium</b>   |  |  |  | e. STREET ADDRESS<br><b>41 Fenton Ave.</b>   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Harriett</b> Middle <b>S</b> Last <b>Young</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>July</b> Day <b>15</b> Year <b>58</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>May 31 1889</b>   |  |
| 9. AGE (In years last birthday) yrs. <b>69</b>   |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>14</b> Hours <b></b> Min. <b></b> |  | IF UNDER 24 HRS.<br>Hours <b></b> Min. <b></b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Rome Kansas</b>                                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>American</b>  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Cyrus Markwood Ludy</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ida Mae Grove</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | 17. INFORMANT<br><b>Evans Young</b> <b>41 Fenton Ave. Williamsport Md.</b>                     |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonitis, bilat.</b><br>DUE TO <b>Acute Cholecystitis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b><br>DUE TO <b></b><br>(c) <b></b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days</b><br><b>3 weeks</b> |  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>492X</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |
| 21. I certify that I attended the deceased from <b>June 23</b> , 19 <b>58</b> , to <b>July 15</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>July 14</b> , 19 <b>58</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>38W. Patuxent Street Williamsport Md.</b> DATE SIGNED <b>July 17, 58</b>                 |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>Paul Haak</b> M.D.   |  |  |  |  |  |  |  |
| PHYSICIAN'S NAME (Type) <b>PAUL HAAK, MD</b>   |  |  |  | <b>Williamsport, Md.</b>   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>July 18-58</b>                                       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Greenlawn Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Williamsport Md.</b>                       |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Albert X. Legg Williamsport, Md.</b>  |  |  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>JUL 18 '58</b>  |  | 24b. REGISTRAR'S SIGNATURE<br><b>Albert X. Legg</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on a burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

ADAM BROWN

|                        |  |                |  |
|------------------------|--|----------------|--|
| Name of Deceased       |  | Adam Brown     |  |
| Age                    |  | 25             |  |
| Sex                    |  | Male           |  |
| Race                   |  | White          |  |
| Date of Death          |  | April 15, 1921 |  |
| Place of Death         |  | Home           |  |
| Cause of Death         |  | Tuberculosis   |  |
| Occupation             |  | Student        |  |
| Residence              |  | Baltimore, Md. |  |
| Signature of Physician |  | [Signature]    |  |
| Signature of Registrar |  | [Signature]    |  |